DOCUMENT RESUME

ED 415 025 PS 026 139

TITLE	Child Health USA '96-'97.
INSTITUTION	Health Resources and Services Administration (DHHS/PHS), Washington, DC. Maternal and Child Health Bureau.
REPORT NO	DHHS-HRSA-M-DSEA-97-48
PUB DATE	1997-09-00
NOTE	83p.; For 1994 edition, see ED 376 387; for 1995 edition, see ED 402 048.
AVAILABLE FROM	U.S. Government Printing Office, Superintendent of Documents, Mail Stop: SSOP, Washington, DC 20402-9328.
PUB TYPE	Numerical/Quantitative Data (110)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	Adolescents; Birth Weight; *Child Health; Day Care; Demography; Dropout Rate; Early Parenthood; Employed Parents; Health Care Costs; *Health Needs; *Incidence; Infant Mortality; Infants; Mortality Rate; Mothers; Municipalities; Poverty; Prenatal Care; *Social Indicators; Tables (Data)
IDENTIFIERS	Health Behavior; Healthy People 2000; Indicators; Medicaid; Vaccination

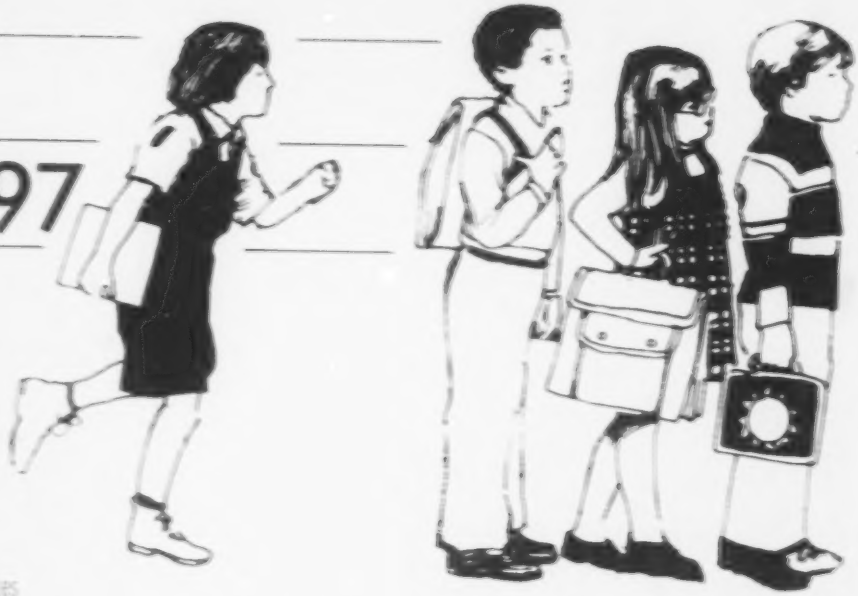
ABSTRACT

Intended to inform policymaking in the public and private sector, this booklet compiles secondary data for 53 health status indicators and service needs of America's children. The book provides both a graphic and textual summary for the data and addresses long-term trends, where applicable. Some statistics indicate the extent of progress toward "Healthy People 2000" goals or a reduction in the prevalence of unhealthy behaviors, while others reveal escalating health problems. Following the introduction, which discusses trends and issues in children's health, the booklet has six sections: (1) "Population Characteristics," including children in poverty, working mothers, child care, and school dropouts; (2) "Health Status," discussing the health issues related to infants, children, and adolescents; (3) "Health Services and Utilization," including health care financing, vaccination coverage levels, physician visits, service utilization by children with chronic conditions, postpartum hospital discharge, and prenatal care; (4) "State-Specific Data," including tables of state-level data on infant, perinatal, and neonatal mortality, prenatal care, low birth weight, births to women under 18, Medicaid information, and health care financing; (5) "City Data," focusing on comparisons between cities with populations over 100,000 and national data on infant mortality, low birth weight, and prenatal care; and (6) Progress Towards Healthy People 2000 Objectives," summarizing progress toward several objectives. Contains approximately 50 references. (KB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

PE

CHILD HEALTH USA '96–'97



ED 415 023

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

X This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

CS 226139

U.S. Department of Health & Human Services
Public Health Service

HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau

BEST COPY AVAILABLE

Child Health USA '96–'97

U.S. Department of Health & Human Services
Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau

MCHB
Maternal and Child Health Bureau

U.S. Department of Health and Human Services
Public Health Service
Health Resources and Services Administration

For sale by the U.S. Government Printing Office
Superintendent of Documents, Mail Stop: SSOP, Washington, DC 20402-9328

EFACE 5
TRODUCTION 6
OPULATION
ARACTERISTICS 10
opulation of Children 11
hildren in Poverty 12
orking Mothers 13
hild Care 13
hool Dropouts 14
EALTH STATUS 16
nt
ow Birth Weight 17
omparison of National
fant Mortality Rates 18
fant Mortality 19
eonatal and Postneonatal Mortality 20
aternal Mortality 21
fant Feeding 22
d
hild Mortality 24
hildhood Deaths Due to Injury 25
ospitalization 26
ospital Discharge Trends 27
ead Exposure 29
diatric AIDS 30
hild Abuse and Neglect 31
ental Caries 32

Adolescent
Adolescent Mortality 34
Adolescent Deaths Due to Injury 35
Teen Pregnancy and
Abortion Rates 36
Sexual Activity and Condom Use 37
Adolescent Childbearing 38
Adolescent AIDS,
by Race/Ethnicity 39
Adolescent AIDS,
by Gender 40
Young Adult AIDS,
by Race/Ethnicity 41
Substance Abuse 42
Cigarette Smoking 43
Physical Activity and Overweight 44

III. HEALTH SERVICES
AND UTILIZATION 46
Health Care Financing 47
Vaccination Coverage Levels 48
Immunization Schedule 49
Physician Visits 50
Place of Physician Contact 51
Hospital Utilization 52
Service Utilization by Children With
Chronic Conditions 54
Postpartum Hospital Discharge 55
Prenatal Care 56

IV. STATE-SPECIFIC
DATA 58
Infant, Perinatal, and
Neonatal Mortality 59
Prenatal Care, Low Birth Weight
and Births to Women Under 18 60
Medicaid Recipients, Expenditures
and ESPDT Services 61
Health Care Financing 62
Uninsured Children (Map) 63

V. CITY DATA 64
Infant Mortality 65
Low and Very Low
Birth Weight 66
Prenatal Care 67

VI. PROGRESS TOWARDS
HEALTHY PEOPLE
2000 OBJECTIVES 68

REFERENCES 74

CONTRIBUTORS 80

BEST COPY AVAILABLE

PREFACE

Child Health USA '96–'97 is the eighth annual report on the health status and service needs of America's children. This book is a compilation of secondary data for 53 health status indicators. It provides both graphical and textual summaries of the data and addresses long-term trends where applicable.

Child Health USA is published to provide the most current data available for public health professionals and other individuals in the private and public sectors. The succinct format of the book is intended to facilitate the use of the information as a snapshot of measures of the health of children in the United States.

Data are presented for the target populations of Title V funding: infants, children, adolescents, and women of childbearing age. In addition to health status, the book addresses health services utilization and population characteristics. This information provides the reader with a multi-dimensional perspective of the health of children in the United States, in accordance with the World Health Organization's definition of health: "A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

The first section, *Population Characteristics*, presents statistics on factors that influence the well-being of children. The second section, entitled *Health Status*, contains vital statistics and health behavior information for infants, children, adolescents, and women of childbearing age. The third section, *Health Services Utilization*, contains data regarding health care financing and newly implemented health policies. The fourth and fifth sections contain information on selected indicators at state and city levels. This edition also includes a special section that cross-references 24 indicators with their respective Healthy People 2000 Objectives.

We hope the information provided in this book will be helpful to policy and decision-makers responsible for implementing or expanding programs that affect the health of children in the United States.

Maternal and Child Health Bureau
Health Resources and Services
Administration

Child Health USA '96-'97 is not copyrighted. Readers are free to duplicate and use all or part of the information contained in this publication. The book is available online on the Maternal and Child Health Bureau's Home Page at **www.os.dhhs.gov/hrsa/mchb/**. Single copies of this publication are also available at no cost from:

National Maternal and Child Health Clearinghouse
2070 Chain Bridge Road, Suite 450
Vienna, VA 22182-2536
(703) 821-8955; fax (703) 821-2098

INTRODUCTION

As a Nation, we demonstrate our commitment to the future through our efforts to ensure the health and well-being of our children, youth and families. Over the course of this century, the rates of maternal and child deaths and illnesses have fallen dramatically, and access to health care has greatly improved. Better sanitation, nutrition, immunization and safety measures have become commonplace, yet new challenges and issues, such as substance abuse and increased violence, have arisen.

As the 21st century begins, the major social, economic, and demographic changes of the last two decades will continue. These changes deeply affect the structure and resources of American families. Fundamental changes in the economies of the U.S. and the world have had a major impact on economic outcomes for millions of families. The permeation of technological innovation has expanded job opportunities for those whose education and skills have kept pace, while it has diminished opportunities (and therefore earning potential) for people with relatively low levels of academic achievement and/or technological skills. At the same time, parents have less time to spend with their children, since in many families parents often work outside the home, holding more than one job in order to meet the family's expenses.

Changes in family composition are also altering the environment in which many children live. In 1995, 59% of children under 18 years of age were living in households headed by a single female. In addition, the geographically diverse distribution of job opportunities has lead to decreased interaction with extended family members for children. Therefore, children are less often left under the care of relatives and more often placed in day care settings, increasing the costs associated with working. Unfortunately, as many families know first-hand, it is possible to be both employed and living in poverty. Even with the current economic prosperity of the Nation, child poverty, which affected 20% of all children in 1995, has risen every year since 1970, reaching 41.5% for African Americans, 39.3% for Hispanics, and 15.5% Caucasians in 1995.

Lack of health insurance coverage for child is also often associated with poverty. Am children under 18 who lived in poverty in 19 65.5% were publicly insured, 21.8% had coverage, and 18.7% were covered by pri insurance. Among *all* children under 18 li in the U.S in 1995, 66.1% were insured vately, 26.4% received their insurance thro public assistance, and 13.8% had no he insurance coverage. Nearly 30% of uninsu children are eligible for Medicaid, but are enrolled in the program. In 1995, an estim 80.3% of uninsured children lived in fam that had at least one parent who worked p time or full-time, for all or part of the year.

In 1995, for every 1,000 live births, infants died within the first year of life. W this was an improvement from the rate of from the previous year, the U.S. has fallen to rank of 25th among industrialized nations. in many regions of the country the infant m tality rate is more than twice the national

Furthermore, the 1995 infant mortality rate among African Americans was 2.4 times higher than that for Caucasians.

In 1995, girls ages 15-17 had babies at a rate of 36 live births for every 1,000 girls, or 3.6%. This was a reduction from the 1994 rate of nearly 3.8%, but much more needs to be done to prevent children from bearing children. In 1990, there were 363,150 abortions in females under age 20. The number decreased by 20 percent to 288,530 (30.7% of all pregnancies in females younger than 20 years of age) in 1994.

Many leading health risks of the past can now be prevented or controlled with early detection and new treatments. But diseases such as Acquired Immune Deficiency Syndrome (AIDS) continue to have a significant impact on the morbidity and mortality rates among children in the United States.

AIDS is taking a terrible toll on our children and youth, but new medications have been shown to be effective treatments to alleviate symptoms and slow the progress of the virus. Similarly, advances in the knowledge, screening, and therapy for reducing the transmission of the HIV virus from pregnant women to their infants are reducing the incidence of perinatal AIDS. The number of cases of pediatric AIDS due to perinatal transmission has decreased 27% since 1992. The new cases of pediatric AIDS reported in 1996 totaled 678 or 1.3% of all cases reported. The number of new adolescent AIDS cases remained constant, with females representing 37% of the new cases. The majority (54%) of cases in adolescent females were the result of heterosexual contact. AIDS education and prevention efforts must continue to target adolescents of both genders.

Another modern epidemic which endangers children, youth, and families is violence. Educators, public health professionals, and parents are striving to understand the sociological causes of violence and to find effective ways to prevent it. In 1995, the number of youths ages 15 to 19 years killed by firearms (including homicides, suicides, and accidents) numbered 4,432. Violence also manifests itself in child abuse. In both 1994 and 1995, over a million children were victims of abuse an neglect, according to child protective service agencies. Nearly 80% of the perpetrators o child abuse in 1995 were parents of the vic tims. Both domestic and societal violenc trends pose enormous challenges to the publi health community.

Cigarette smoking continued to rise in 199 among American youth. Thirty percent o tenth graders said that they had smoked ciga rettes 30 days prior to being surveyed, a increase of 0.9% from 1995. The rates fo eighth graders and high school seniors als increased. Perhaps the best news is that th tobacco industry has acknowledged that smok ng is a serious health hazard.

After four years of rising rates, the use o marijuana and other illegal drugs by teenager appears to have declined slightly since 199 although it is still unacceptably high. In 199 7.1% of youths ages 12 to 17 had reporte using marijuana in the month before the were interviewed compared to 8.2% in 199 Similarly, a long-term decline in alcohol con

sumption among teenagers continued in 1996, with 18.8% of youths ages 12 to 17 acknowledging recent alcohol use, down from 21.1% in 1995. With strong support from the Administration, substance abuse is being attacked with renewed vigor.

The concept of health has been expanded to include the social, cultural and environmental context in which children and families function. Maternal and child health programs and services across the Nation are forming innovative partnerships with each other, professional associations, businesses, academic institutions, and a variety of government agencies. In the health policy climate of today, these partnerships are being encouraged, extended, and strengthened.

The resulting efforts and programs in every area of maternal and child health are both encouraging and impressive. This issue of *Child Health USA* provides the reader with a picture of both the long-term progress that has been made, and the challenges that remain in many areas of maternal and child health. Specifically, this edition presents a matrix* of 24 indicators in relation to their counterpart Healthy People 2000 (HP2000) Objectives for the Nation.

In 1990, a consortium of government, voluntary, and professional organizations developed the Healthy People 2000 (HP2000) Objectives for the Nation, which included a total of 319 objectives within 22 priority areas, such as nutrition, family planning, and clinical preventive services.

By the time the U.S. Department of Health and Human Services published its 1995 *Midcourse Review* of progress towards the HP2000 Objectives, 42 states, the District of Columbia, and Guam had established their own statewide objectives. Many states noted that the lack of consistency in the ways specific populations were measured across surveys was a barrier in the objectives-setting process. This same barrier influences the presentation of data in the matrix within this edition of *Child Health USA*. Therefore, some measures used to calculate rates may not be identical. However, the statistics presented in this book will provide readers with timely and accurate information that allows for an overview of progress towards the Nation's HP2000 Objectives for maternal and child health.

**The data in the matrix are ordered by HP 2000 Objective number to facilitate cross-referencing within the Public Health Service's* Healthy People 2000: National Health Promotion and Disease Prevention Objectives *publication.*

BEST COPY AVAILABLE

Courtesy of Egleston Children's Hospital

POPULATION CHARACTERISTICS

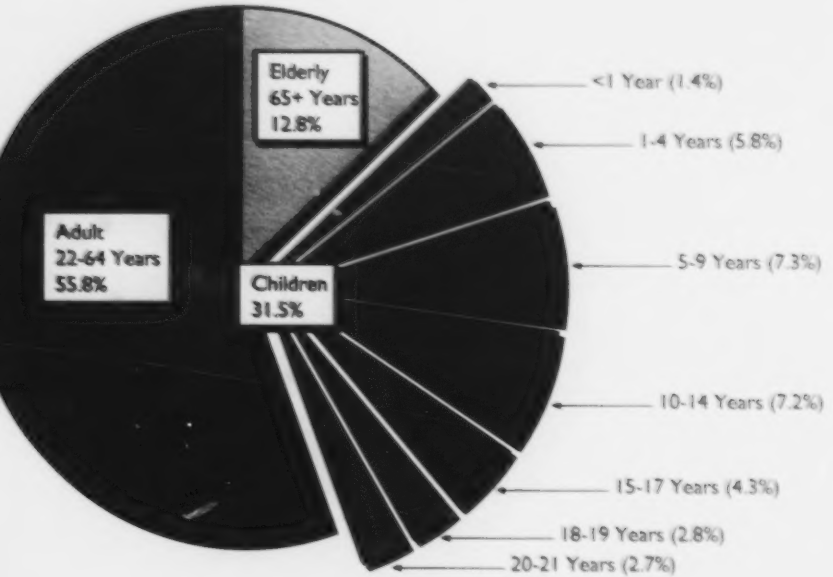
Socio-demographic characteristics provide a comprehensive picture of the country's diverse maternal and child population. Through the year 2000 the proportion of children through the age of 21 is projected to remain at 31.5%.

At the national, state, and local levels, policy-makers use population information to systematically address health-related issues of mothers and children. By carefully analyzing and comparing data, health workers can often isolate high-risk populations that require specific interventions. Policy-makers can then tailor programs to meet the needs of those populations.

The following section presents data on several population characteristics that have an impact on maternal and child health program development and evaluation. These include age, poverty status, living arrangements by head of household, school dropout rates, and child care trends.

RESIDENT POPULATION BY AGE GROUP: JULY 1,1996

(U.S. Bureau of the Census



POPULATION OF CHILDREN

In 1996, the 83 million children through the age of 21 in the United States, represented 31.5% of the total population. Persons aged 65 and over represented 12.8% of the total population. The median age in the United States for all races was 34.6.

Since July 1, 1990, the number of children under 5 years of age has increased by 2.3% and the number of children ages 5 to 17 has increased by 9.8%. Through the year 2000, the proportion of children through the age of 21 is projected to remain between 31.5% and 31.6%.

CHILDREN IN POVERTY

In 1995, there were 14 million related* children under 18 years of age living in families with income below the Federal poverty level of $15,569** for a family of four. This population comprised 20% (1 in 5) of all related children living in families.

Between 1980 and 1995, the number of children living in poverty increased by almost 2.9 million. In contrast, the number of persons 65 years of age and over living in poverty decreased by nearly 0.6 million.

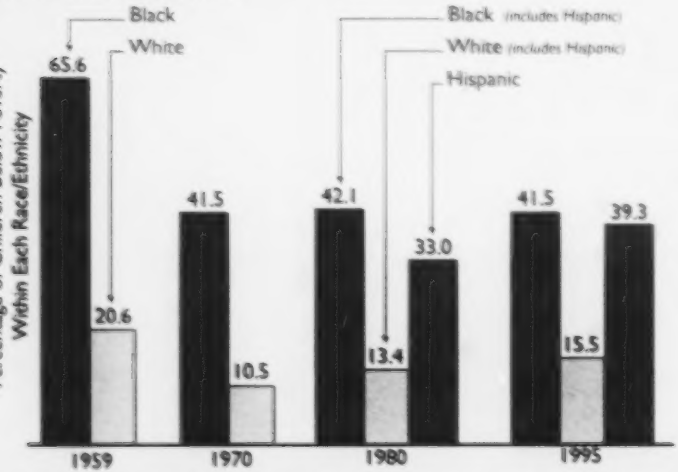
Of the 14 million related children under 18 years of age living in families with income below the Federal poverty level, 59% lived in homes headed by only a mother, 36% lived in homes headed by married parents, and 5% lived in homes headed only by a father.

*Related children in a family include householder's own children and all other children in the household who are related to the householder by blood, marriage or adoption.

**Based on the U.S. Census Bureau's poverty threshold, which is calculated using the Consumer Price Index from the previous calendar year.

RELATED CHILDREN UNDER 18 YEARS OF AGE LIVING IN FAMILIES BELOW 100% OF POVERTY LEVEL: 1995

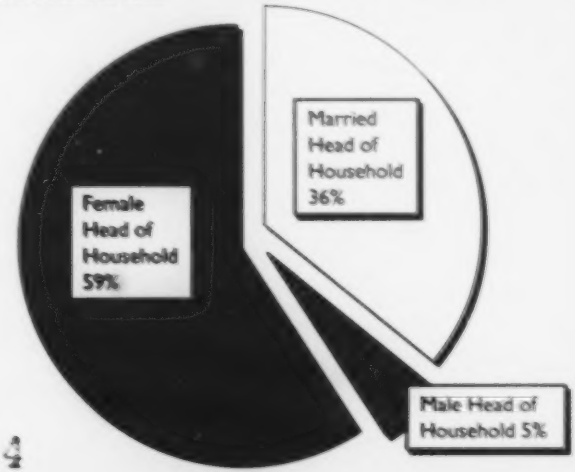
Source (L2): U.S. Bureau of the Census



Note: Ethnicity data are not available prior to 1979.

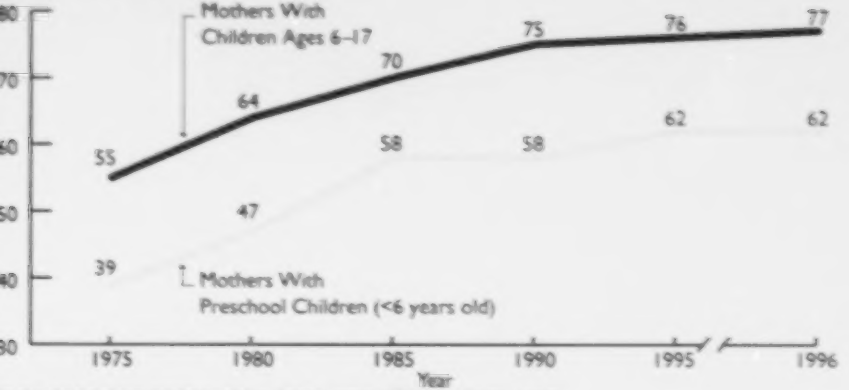
RELATED CHILDREN UNDER 18 YEARS OF AGE LIVING IN FAMILIES BELOW 100% OF POVERTY LEVEL, BY HEAD OF HOUSEHOLD STATUS: 1995

Source (L3): U.S. Bureau of the Census



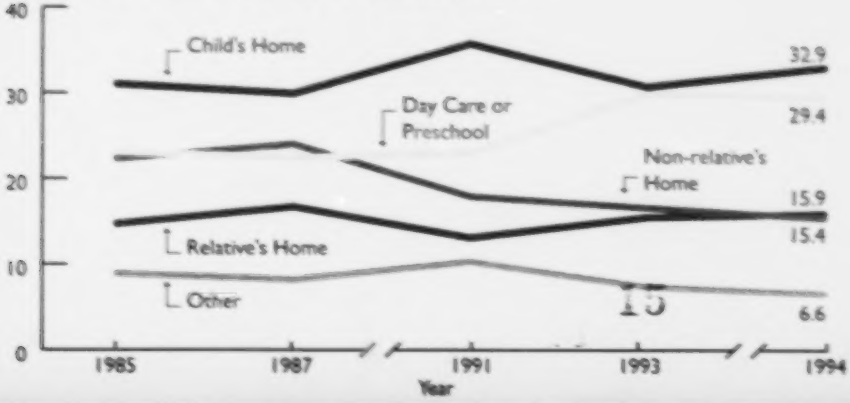
HERS IN THE LABOR FORCE: 1975–1996

(1.4) U.S. Bureau of Labor Statistics



E OF CARE FOR PRESCHOOL-AGED CHILDREN: 1985–1993

(1.5) U.S. Bureau of the Census, Survey of Income and Program Participation (SIPP)



WORKING MOTHERS

In 1996, 62% of all mothers with preschool-aged children (younger than 6 years) were in the labor force (working or seeking employment). Approximately 58% of mothers with preschool-aged children were actually employed. Of those mothers, 67% were employed full-time; 33% were employed part-time.

In 1996, nearly 77% of women with children ages 6-17 were in the labor force, while nearly 74% were actually employed. Of those mothers, over 74% were employed full-time; 26% of working mothers were employed part-time.

**Data for 1994 and 1995 are not strictly comparable with data for earlier years due to changes in the survey and the estimation process.*

CHILD CARE

In 1994, 3 out of 10 children younger than age 5 (3.0 million) whose mothers were employed* spent their days in nonresidential day care centers.

Women who work full time tend to use day care centers while women who work part time are more likely to use in-home care.

**Some of those mothers may have worked at home.*

SCHOOL DROPOUTS

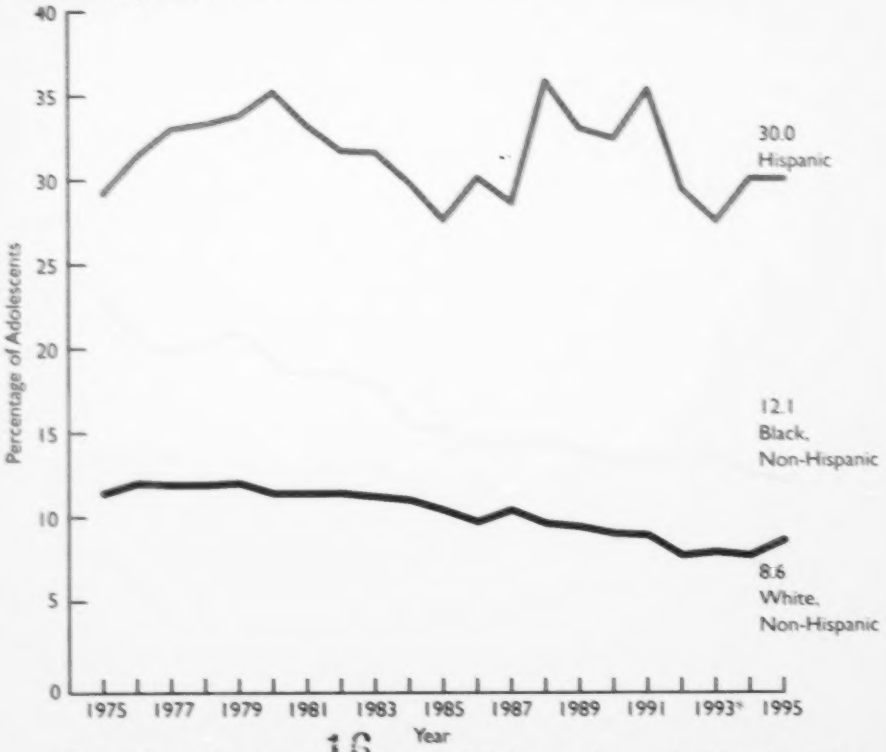
In 1995, almost 3.9 million 16 to 24 year olds were not in school and had not completed high school. Those who dropped out of high school represent 12% of the young adult population.

In 1995, almost one third of young Hispanics had dropped out of high school. The difference between the dropout rates of black and white young adults has narrowed considerably in the last 25 years, as the dropout rate decreased faster for blacks than for whites.

A 1992 National Education Longitudinal Study of 10th through 12th grade dropouts revealed that the top four reasons for dropping out were: not liking school (42.9%); failing school (38.7%); not being able to keep up with school work (31.3%); and finding a job (28.5%). Female dropouts were more likely than male dropouts to report family-related reasons. Twenty-one percent of female dropouts left because they became a parent, compared with only 8% of male dropouts.

STATUS SCHOOL DROPOUT RATES FOR YOUNG PEOPLE AGES 16–24 BY RACE/ETHNICITY: 1975–1995

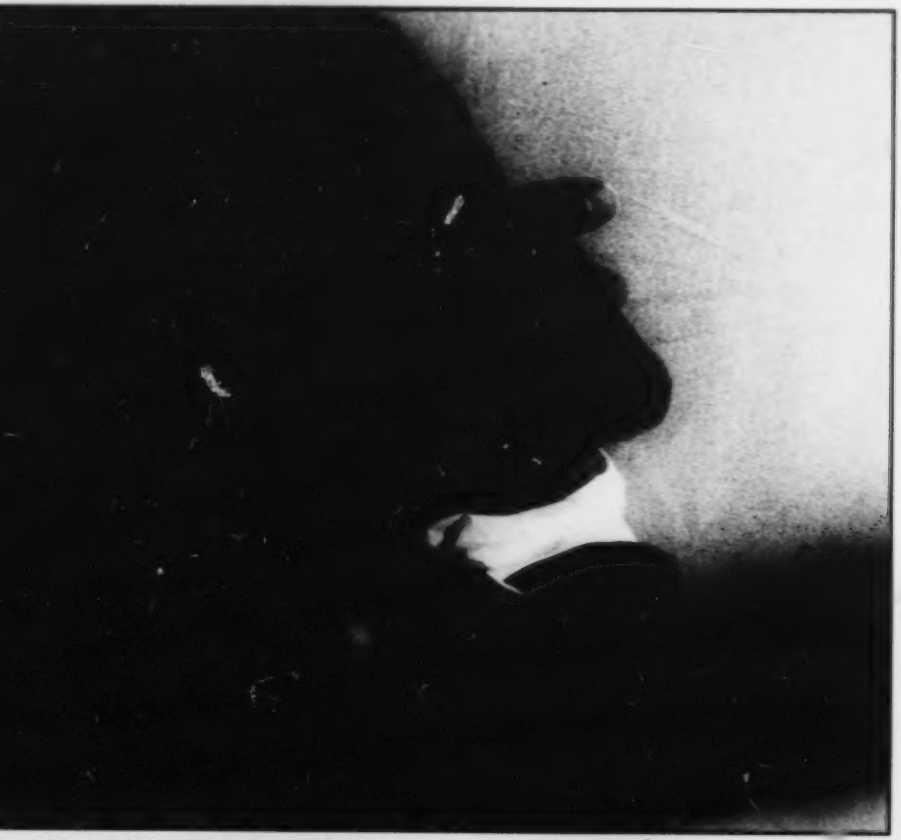
Source (List): U.S. Department of Education



*Because of changes in data collection procedures beginning in 1992, data may not be comparable with figures for earlier years.

Note: Status rates measure the proportion of the population who have not completed high school and are not enrolled at one point in time, regardless of when they dropped out.

BEST COPY AVAILABLE



rtesy of Arnold Palmer Hospital for Children and Women

HEALTH STATUS

The systematic assessment of the health status of children enables health professionals to determine the impact of past and current health intervention and prevention programs. Program planners and policy-makers identify trends by examining and comparing information from one data collection year to the next. Although indicators are often assessed on an annual basis, some surveillance systems may only collect data every two, three, or five years.

In the following section, mortality, disease, injury, and health behavior indicators are presented by age group. The health status indicators in this section are based on vital statistics and national surveys. Population-based samples are designed to yield data that are representative of the maternal and child population affected by, or in need of, specific health services.

BEST COPY AVAILABLE

OW BIRTH WEIGHT

n 1995, 285,152 babies (7.3% of all live hs) were of low birth weight, weighing less n 2,500 grams, or 5.5 pounds, at birth.

The percentage of low birth weight births ong all live births rose from a low of % in 1985 to 7.3% in 1995. From 1994 to 95, rates among blacks decreased, while s among American Indians, Hispanics and tes increased.

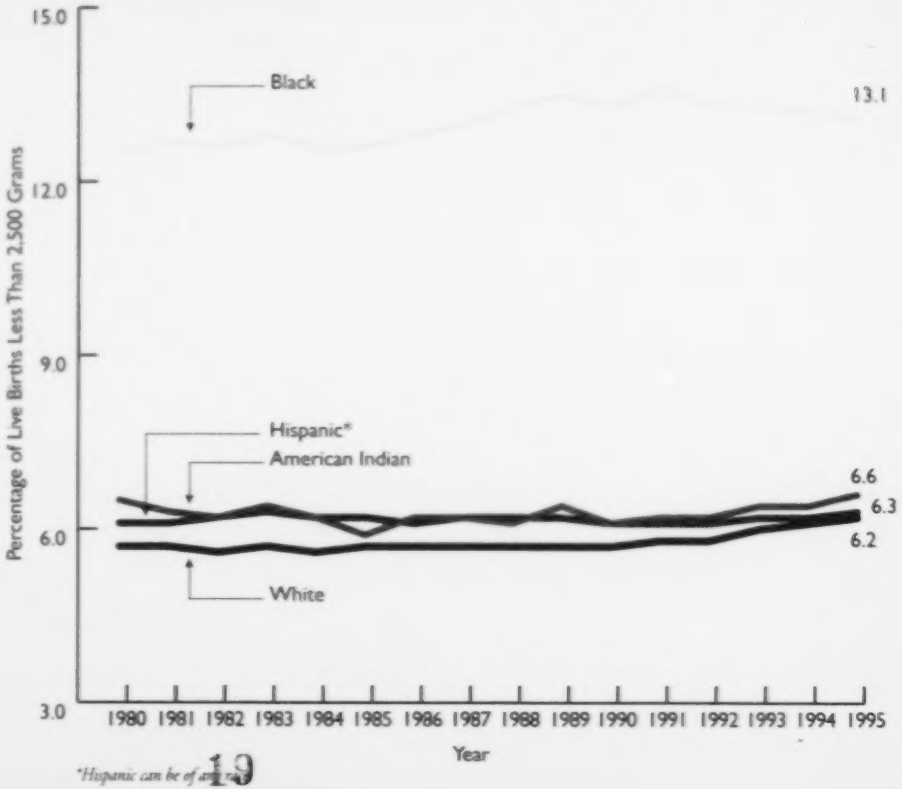
ow birth weight is the factor most closely ciated with neonatal mortality. Low birth ght infants are more likely to experience g-term disabilities or to die during the first of life than are infants of normal weight.

n 1995, 12.2% of infants born to smokers e of low birth weight, compared with 6.8% irths to nonsmokers. This nearly twofold erential has been observed since 1989 ong both black and white infants. Other fac- associated with increased risk of low birth ght include poverty, low level of educational inment, and minority status.

1980-1988 data based on race of child, 1989-1995 data based on f mother.

PERCENTAGE OF LOW BIRTH WEIGHT INFANTS BY RACE: 1980–1995

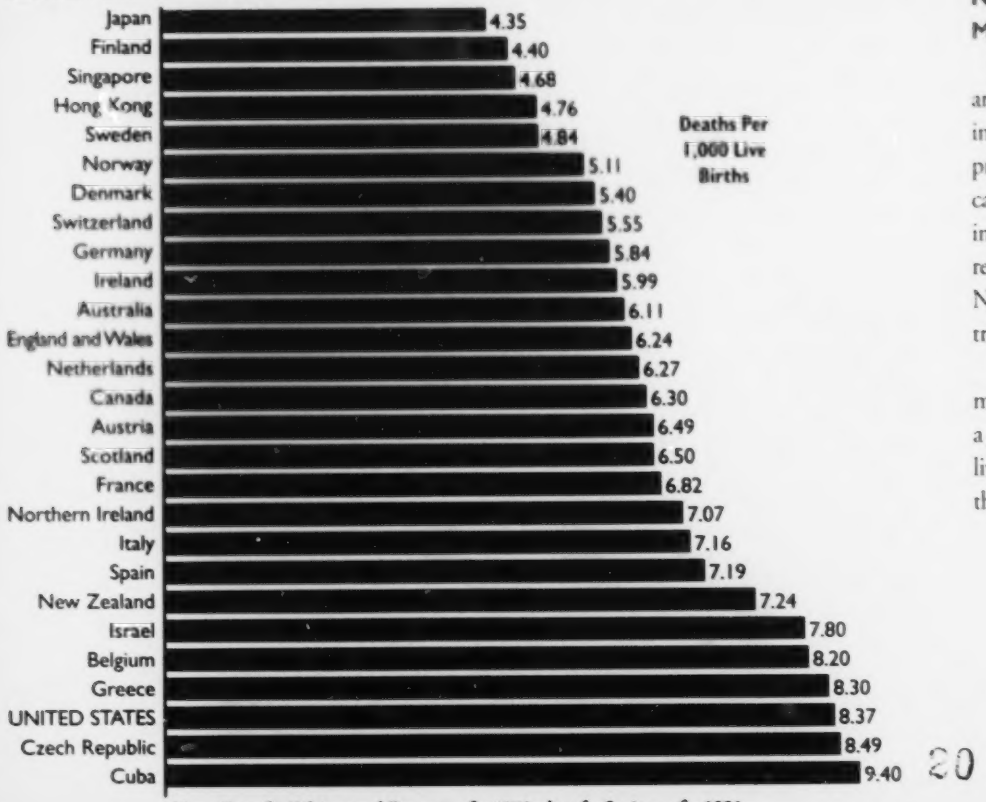
Source (II.1): National Center for Health Statistics



*Hispanic can be of any race

COMPARISON OF NATIONAL INFANT MORTALITY RATES: 1993

Source (II.2): National Center for Health Statistics



Note: Data for Belgium and France are for 1992; data for Spain are for 1991.

COMPARISON OF NATIONAL INFANT MORTALITY RATES

Differences in the infant mortality rates among industrialized nations reflect differences in the health status of women before and during pregnancy and the quality of primary health care accessible to pregnant women and their infants. Although the United States has greatly reduced its infant mortality rate since 1965, the Nation ranked 25th among industrialized countries in 1993.

Since 1980, Japan has had the lowest infant mortality rate in the world. In 1993, the risk of a Japanese child dying in infancy (4.4 per 1,000 live births) was 48% lower than that observed in the United States (8.4 per 1,000 live births).

INFANT MORTALITY

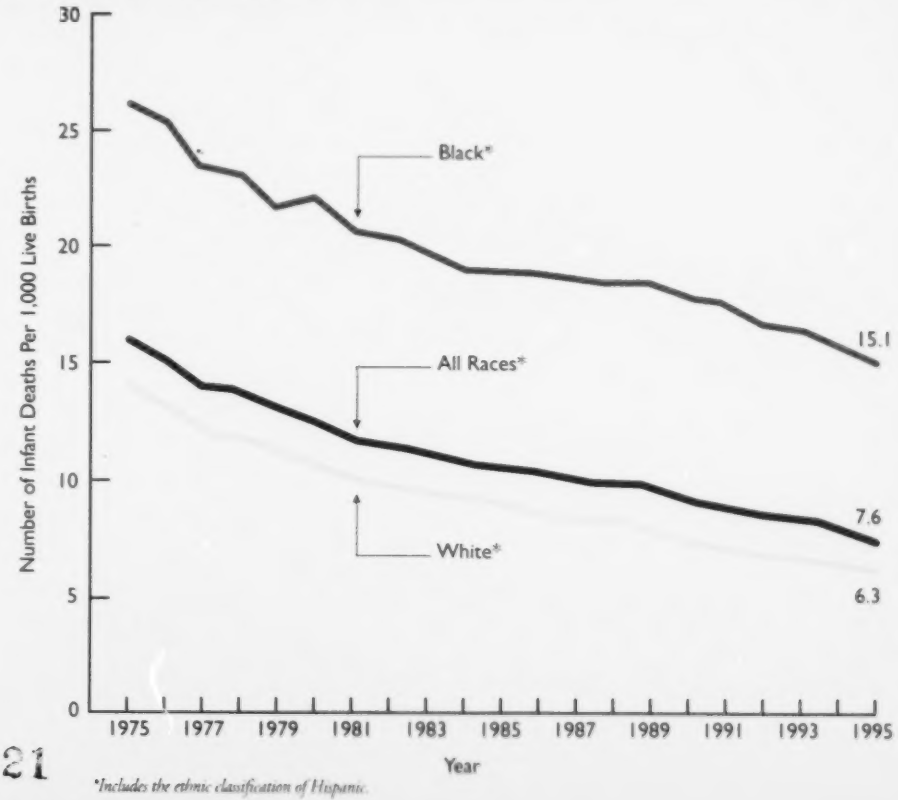
In 1995, 29,583 infants died before their first birthday. The infant mortality rate was 7.6 deaths per 1,000 live births. This figure represents a decline of 5% from the rate of 8.0 for the previous year.

The rapid decline in infant mortality, which began in the mid 1960s, slowed for both blacks and whites during the 1980s.

The 1995 infant mortality rate for black infants was 2.4 times the rate for white infants. Although the trend in infant mortality rates among blacks and whites has been on a continual decline throughout the 20th century, the proportional discrepancy between black and white rates has remained largely unchanged.

U.S. INFANT MORTALITY RATES BY RACE OF MOTHER: 1975–1995

Source (II.3): National Center for Health Statistics



21

*Includes the ethnic classification of Hispanic.

NEONATAL AND POSTNEONATAL MORTALITY

Neonatal

In 1995, 19,155 infants younger than 28 days died, resulting in a neonatal mortality rate of 491.2 deaths per 100,000 live births. Both the overall mortality rate and rates by most leading causes of mortality decreased from 1994 to 1995.

Disorders resulting from short gestation and low birth weight are the primary causes of neonatal mortality for blacks, while congenital anomalies are the leading cause for whites.

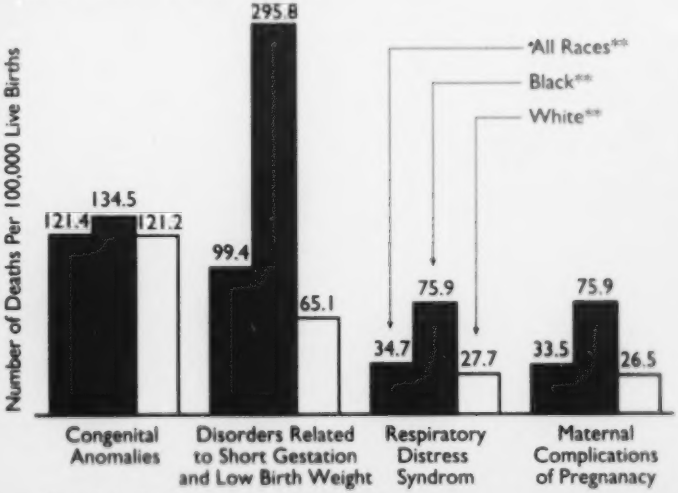
Postneonatal

In 1995, 10,428 infants 28 days to 11 mont old died; the postneonatal mortality rate w 267.4 deaths per 100,000 live births, a decrea of 7% from 1994.

The postneonatal mortality rate for blacks at least two times that for whites for most the leading causes of postneonatal mortality

LEADING CAUSES OF NEONATAL* MORTALITY: 1995

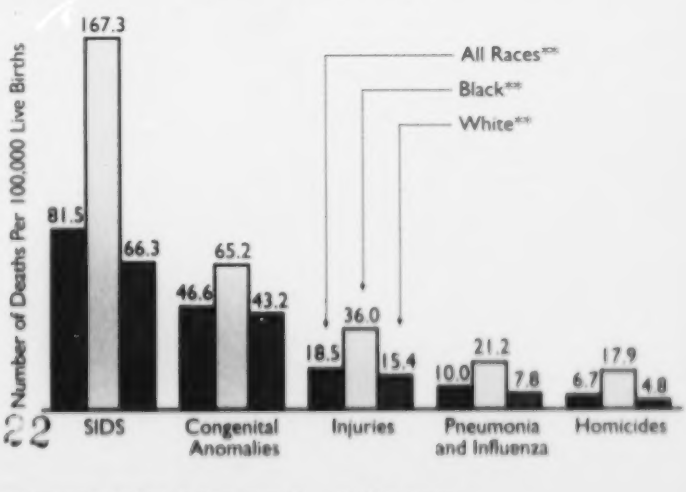
Source (II.4): National Center for Health Statistics



*Neonatal: less than 28 days old. **Includes Hispanic.

LEADING CAUSES OF POSTNEONATAL* MORTALITY: 1995

Source (II.5): National Center for Health Statistics



*Postneonatal: 28 days to less than one year old. **Includes Hispanic.

MATERNAL MORTALITY

During the past several decades, there has been a dramatic decrease in maternal mortality in the United States. Since 1980, however, the rate of decline has slowed.

In 1995, there were 277 maternal deaths which resulted from complications during pregnancy, childbirth, or the postpartum period.

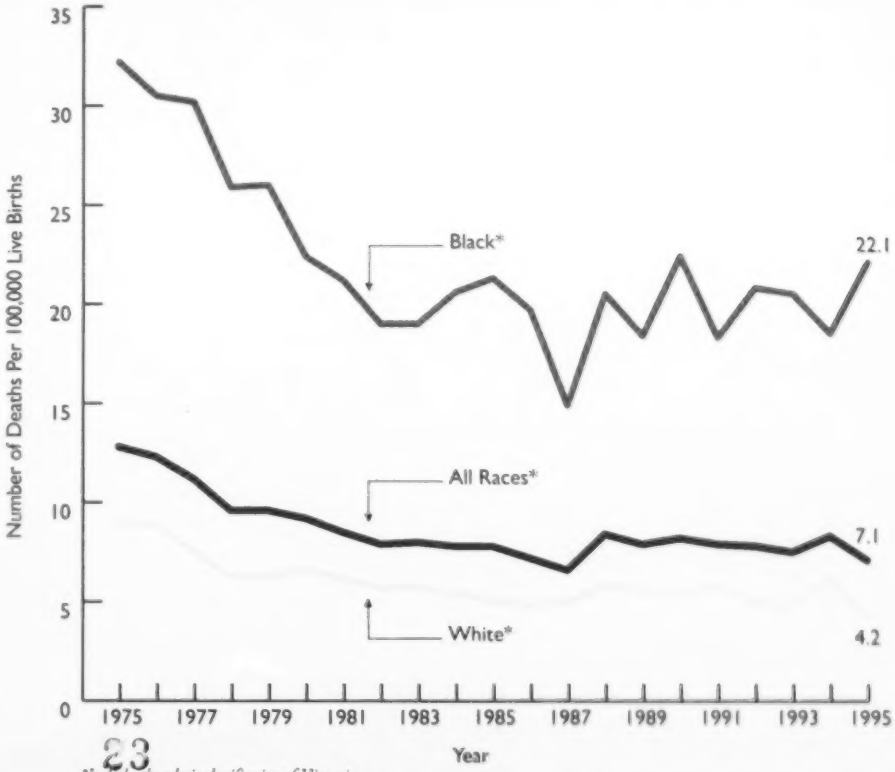
The maternal mortality rate for black women (22.1 per 100,000 live births) is more than five times the rate for white women (4.2 per 100,000 live births).

Regardless of race, the risk of maternal death increases for women over age 30; women 35-39 years old have more than twice the risk of maternal death than those aged 20-24 years.

Note: Data based on race of mother.

MATERNAL MORTALITY RATES BY RACE OF MOTHER: 1975–1995

Source (II.6): National Center for Health Statistics



*Includes the ethnic classification of Hispanic.

INFANT FEEDING

From 1976 to 1982, the percentage of mothers who began breastfeeding in the hospital reached a high of 61.9%, but then gradually declined to 51.5% by 1990. Since 1991, however, there has been an increase for black, Hispanic, and white women. The total in-hospital breastfeeding rate for 1996 was 59.2%.

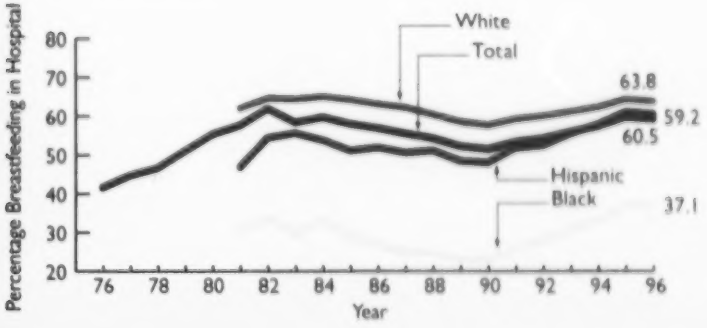
With steeper increases in the rate of breastfeeding for black women, the gap between breastfeeding rates for black and white women narrowed slightly in 1996, but was still nearly twice as high for white women as for black women. The 1996 rates for Hispanic women averaged 6.2% lower than those for white women.

Breastfeeding rates for women of all races decrease substantially between delivery and 5 to 6 months postpartum, the breastfeeding period recommended as most critical for the infant's health by the Surgeon General of the United States. The 1996 rates at 5 to 6 months postpartum were only 26.0%, 21.1% and 12.1% for white, Hispanic, and black women respectively, representing a decline from the rates just after delivery of 37.8% among whites, 39.4% among Hispanics, and 25.0% among blacks.

Breastfeeding rates were highest among women over 30 years of age, college educated, relatively affluent, not participating in the Women, Infants, and Children (WIC) dietary supplement program, and/or living in the western United States. Women were also more likely to breastfeed their first child. Women least likely to breastfeed were younger than 20 years of age, employed full-time, low income (<$10,000/year), black and/or living in the southeastern United States.

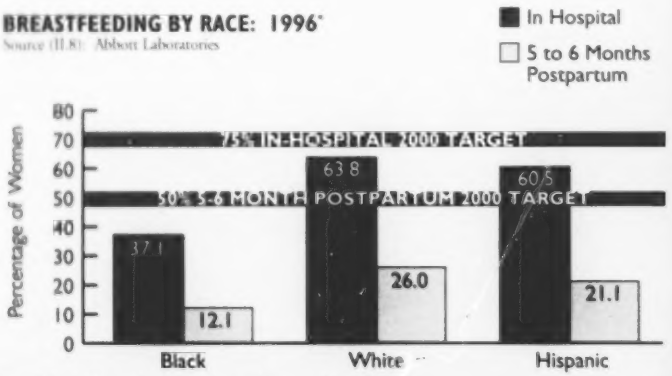
TRENDS IN BREASTFEEDING BY RACE: 1976–1996

Source (II.7): Abbott Laboratories



BREASTFEEDING BY RACE: 1996*

Source (II.8): Abbott Laboratories



* *Includes exclusive and supplemented breastfeeding.*

CHILD MORTALITY

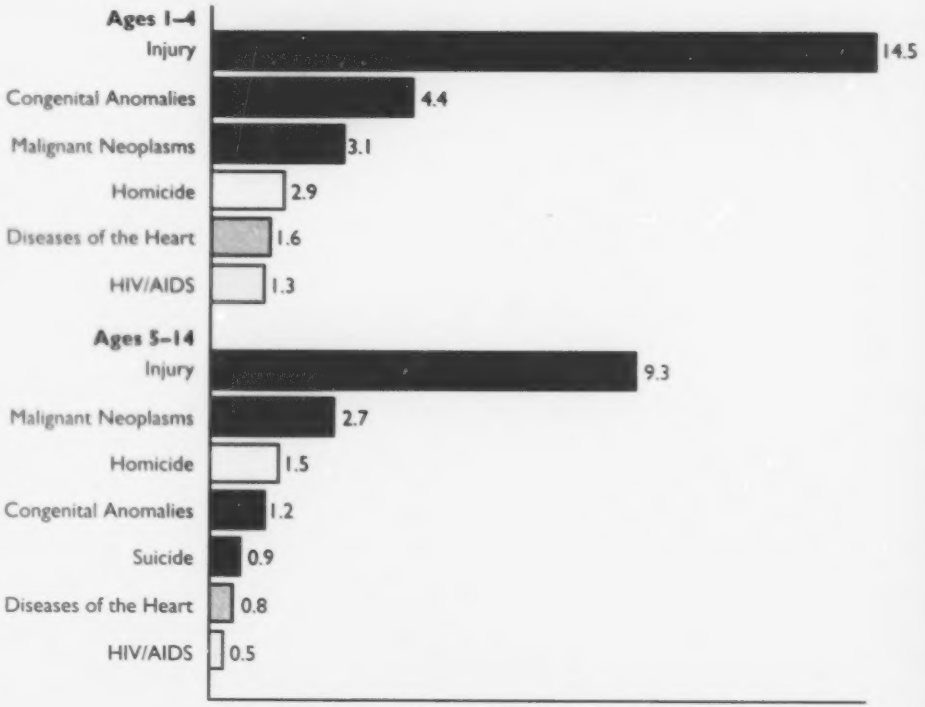
There were 14,989 deaths of children ages 1–14 in 1995. Injury, of any type, and regardless of intent, was the primary cause of death in that age group. Among 1–4 year old children, injuries accounted for 36% of all deaths, followed by deaths due to congenital anomalies (birth defects), malignant neoplasms (tumors), homicide, diseases of the heart, and HIV or AIDS.

Injuries comprised 41% of all deaths among 5–14 year old children, followed by malignant neoplasms, homicide, congenital anomalies, suicide, diseases of the heart, and HIV or AIDS.

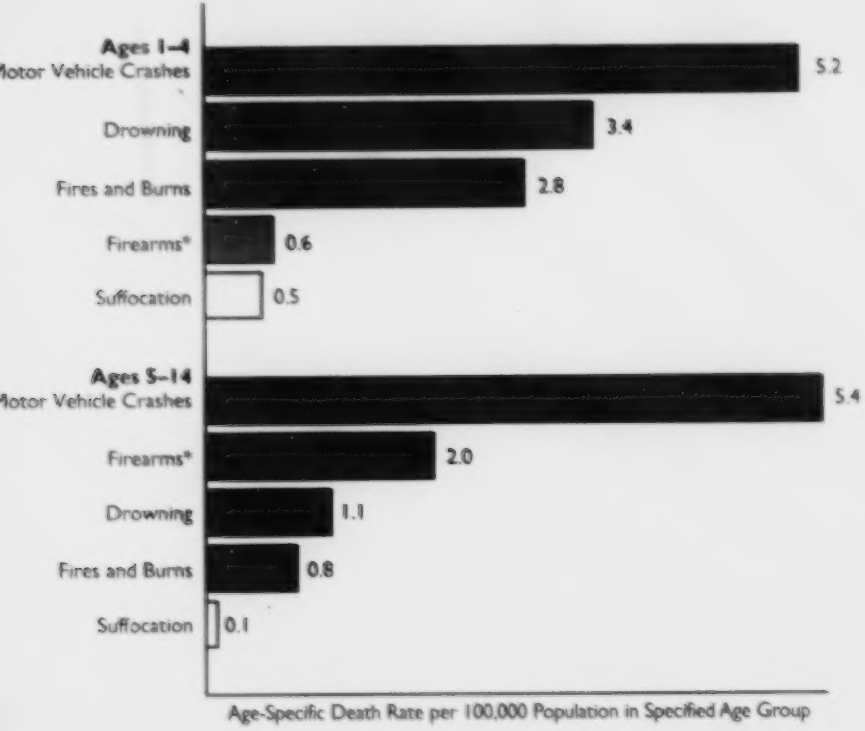
Childhood death rates have declined substantially over the past several decades. Death rates for those aged 1–4 years decreased 5% from 1994 while there was no change in rates for those aged 5–14 years.

LEADING CAUSES OF DEATH IN CHILDREN AGES 1–14: 1995

Source (II.9): National Center for Health Statistics



HILDHOOD DEATHS DUE TO EXTERNAL CAUSE, BY CAUSE AND AGE: 1995
ance (II.10): National Center for Health Statistics



*Firearm-related deaths include homicides, suicides, and accidents.

CHILDHOOD DEATHS DUE TO INJURY

In 1995, injuries caused the deaths of 2,280 1–4 year old children and 3,544 5–14 year old children.

Among 1–4 year old children, motor vehicle crashes, drowning, and fire were the leading causes of injury death. Motor vehicle crashes were the leading cause of injury death among 5–14 year old children, followed by firearm deaths. About 51% of firearm deaths among 5–14 year old children were homicides.

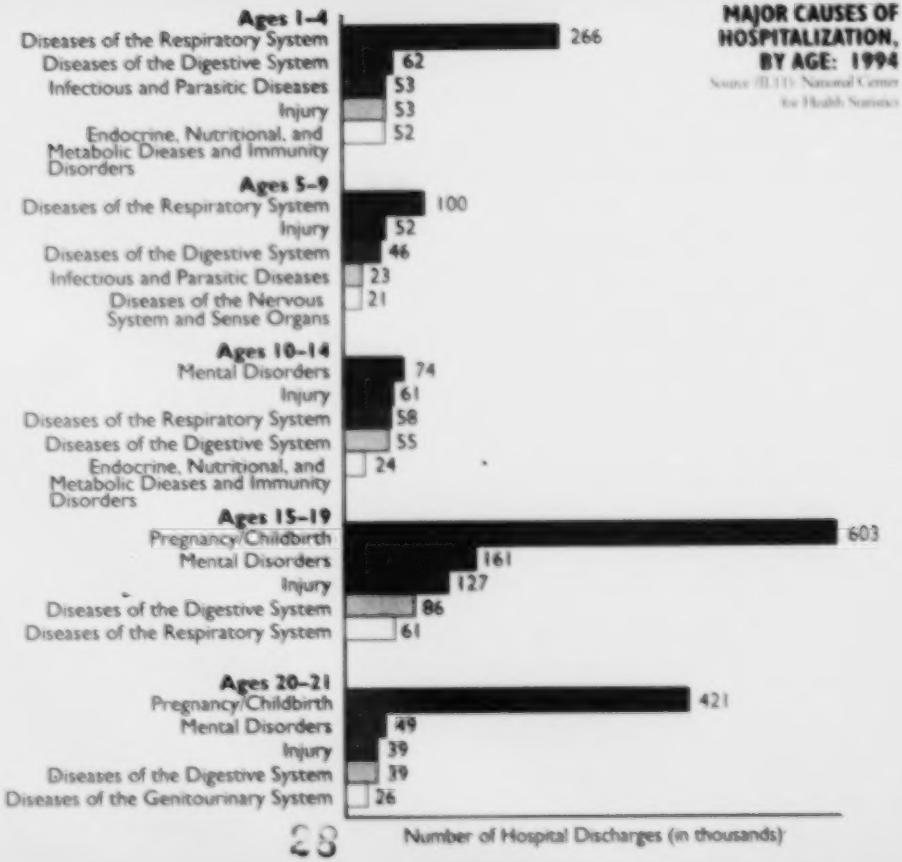
HOSPITALIZATION

In 1994, there were 3.5 million hospital discharges of children 1 through 21 years old, or 4.5 discharges per 100 children in that year.

Diseases of the respiratory system were the major cause of hospitalization of children 1–9 years of age and accounted for 34% of their discharges.

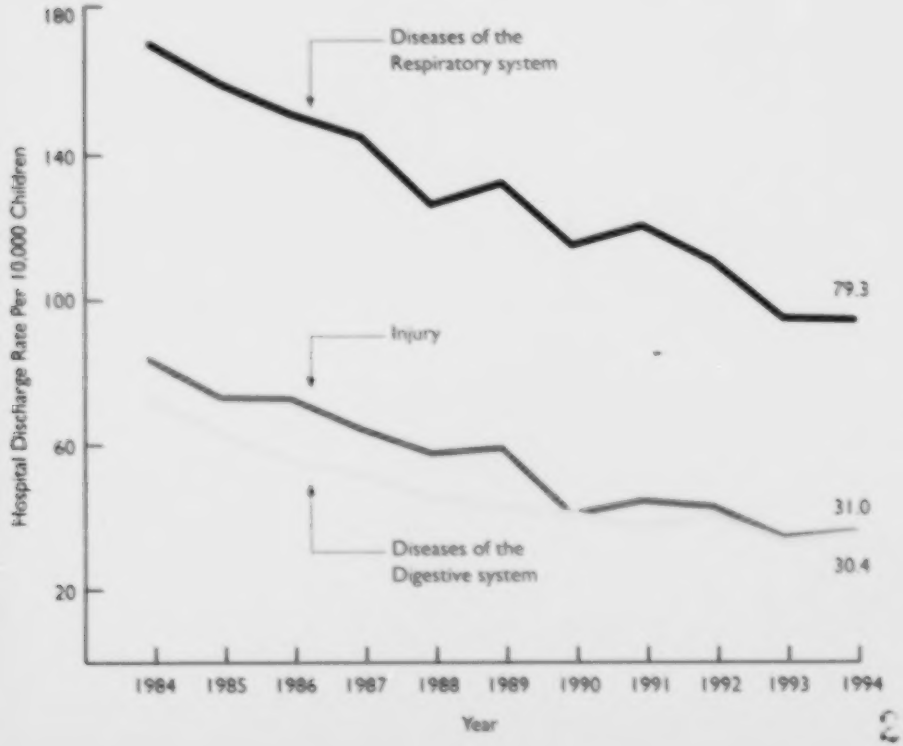
Hospital discharge rates decrease with age until age 9 and then increase during later adolescence.

While injuries are the leading cause of death for children older than 1 year, this category accounted for only 11% of the hospital discharges of children 1–14 years in 1994. Pregnancy and childbirth related hospitalizations accounted for 68% of discharges of young women ages 15–21.


MAJOR CAUSES OF HOSPITALIZATION, BY AGE: 1994
Source: (LLU) National Center for Health Statistics
Ages 1–4
Diseases of the Respiratory System 266
Diseases of the Digestive System 62
Infectious and Parasitic Diseases 53
Injury 53
Endocrine, Nutritional, and Metabolic Dieases and Immunity Disorders 52
Ages 5–9
Diseases of the Respiratory System 100
Injury 52
Diseases of the Digestive System 46
Infectious and Parasitic Diseases 23
Diseases of the Nervous System and Sense Organs 21
Ages 10–14
Mental Disorders 74
Injury 61
Diseases of the Respiratory System 58
Diseases of the Digestive System 55
Endocrine, Nutritional, and Metabolic Dieases and Immunity Disorders 24
Ages 15–19
Pregnancy/Childbirth 603
Mental Disorders 161
Injury 127
Diseases of the Digestive System 86
Diseases of the Respiratory System 61
Ages 20–21
Pregnancy/Childbirth 421
Mental Disorders 49
Injury 39
Diseases of the Digestive System 39
Diseases of the Genitourinary System 26
Number of Hospital Discharges (in thousands)

DISCHARGE RATE OF PATIENTS 1–14 YEARS OLD FOR SELECTED DIAGNOSES: 1984–1994

Source (II.12): National Center for Health Statistics



29

HOSPITAL DISCHARGE TRENDS

Since 1984, there has been a 43% decrease in overall hospital discharge rates for children aged 1–14 years.

Between 1984 and 1994, there was a 44% decline in the hospital discharge rate for diseases of the respiratory system in children aged 1–14 years.

Three diagnostic categories (respiratory disease, injury, and digestive disease) accounted for 50% of the discharges of children aged 1–14 years in 1994.

Courtesy of Paul Vincent Kunz, Texas Children's Hospital

BEST COPY AVAILABLE

LEAD EXPOSURE

Childhood lead exposure is a preventable environmental health problem that usually occurs in residential settings. The most common source of lead exposure for children is lead-based paint that has deteriorated into paint chips and lead dust. In the U.S., approximately 83% of privately owned homes and 86% of public housing units built before 1980 contain some lead-based paint.

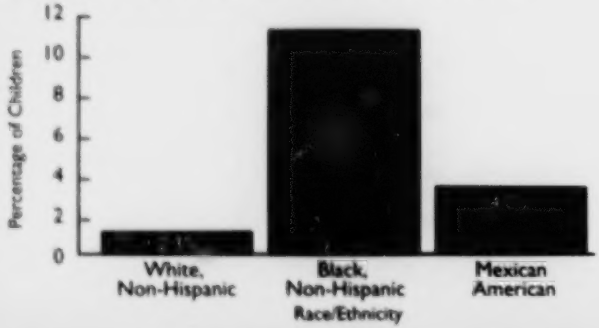
Blood lead levels (BLLs) as low as 10 ug/dL (micrograms per deciliter) can adversely affect the behavior and development of children. Epidemiologic studies have demonstrated an inverse relationship between early exposure to low levels of lead and cognitive ability in later years. Screening efforts are necessary for early identification of children with elevated BLLs to enable prompt and appropriate environmental, educational, and medical interventions.

Phase II of the Third National Health and Nutrition Examination Survey (NHANES III: 1991–1994) revealed that the geometric mean BLL in persons ages 1 to 74 years was 2.3ug/dL —down from 12.8 ug/dL in 1976. The dramatic decline in BLLs is probably a direct consequence of the regulatory and voluntary bans enacted during this period on the use of lead in gasoline, household paint, food and drink cans, and plumbing systems.

Despite the substantial progress in eliminating sources of lead in the U.S., nearly one million children ages 1 to 5 years had elevated BLLs (≥10 ug/dL). Results of NHANES III indicated that the risk of elevated BLLs was highest among children who were poor, non-Hispanic black, living in large metropolitan areas, or living in older housing.

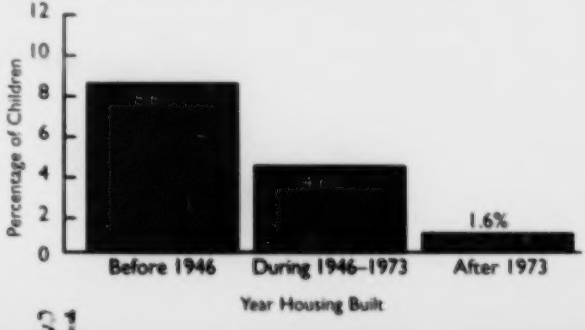
PERCENTAGE OF CHILDREN AGES 1 TO 5 WITH ELEVATED BLOOD LEAD LEVELS (≥ 10 ug/dL), BY RACE/ETHNICITY

Source (IL13): National Center for Health Statistics: NHANES III–Phase 2 (1991–1994)



PERCENTAGE OF CHILDREN AGES 1 TO 5 WITH ELEVATED BLOOD LEAD LEVELS (≥ 10 ug/dL), BY YEAR HOUSING BUILT

Source (IL14): National Center for Health Statistics: NHANES III–Phase 2 (1991–1994)



PEDIATRIC AIDS

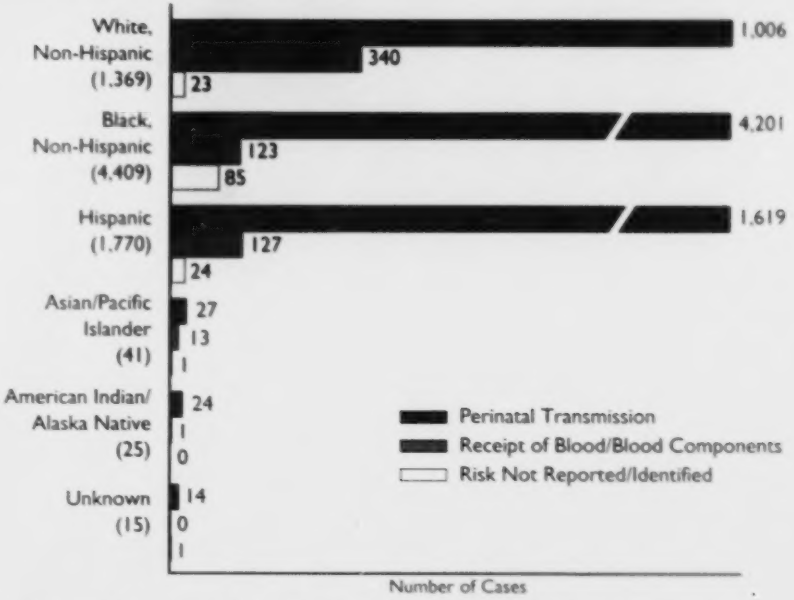
As of December 31, 1996, 7,629 cases of AIDS in children younger than 13 years old had been reported in the U.S.; this total includes 678 newly reported cases in 1996. Pediatric AIDS cases represented approximately 1.3% of all cases reported.

The majority of AIDS cases result from transmission before or during birth (perinatal transmission). However, the number of cases of pediatric AIDS due to perinatal transmission has decreased 27% since 1992. A contributing factor to this substantial decrease is the Public Health Service's recommendations. In 1994, zidovudine (ZDV) treatment was recommended to reduce perinatal transmission; in 1995, routine HIV counseling and voluntary testing for all pregnant women was recommended.

The number of cases of pediatric AIDS in Black, non-Hispanic children is over three times greater than the number of cases in White, non-Hispanic children and two and one-half times greater than the number of cases in Hispanic children.

PEDIATRIC AIDS CASES BY RACE/ETHNICITY AND EXPOSURE CATEGORY: 1981–1996

Source (IL15): Centers for Disease Control and Prevention



Notes: Perinatal Transmission—Child's biologic mother had:
- *Injecting drug use*
- *Sex with injecting drug user*
- *Sex with bisexual male*
- *Sex with person with hemophilia*
- *Sex with transfusion recipient with HIV infection*
- *Sex with person with HIV infection, risk not specified*
- *Receipt of blood transfusion, blood components, or tissue*
- *Has HIV infection, risk not specified*

Receipt of Blood/Blood Components:
- *Received clotting factor for hemophilia/coagulation disorder*
- *Received blood transfusion, blood components, or tissue*

CHILD ABUSE AND NEGLECT

In 1995, investigations by child protective services agencies in 49 states determined that 1,000,502 children were victims of substantiated or indicated child abuse and neglect, a rate equivalent to 15 per 1,000 children younger than 18 years of age. Nearly 80% of the perpetrators of child maltreatment were the parents of the victims. Another 10% were other relatives of the victims, and 2 percent were persons in other caretaking roles (i.e., foster parents, facility staff, and child care providers).

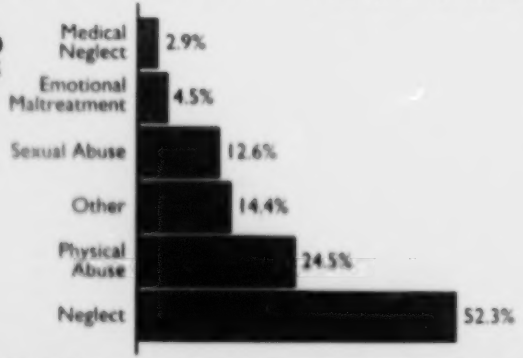
Approximately 26% of all victims were younger than 4 years old; more than half were 7 years of age or younger; about 26% were ages 8–12; and 21% were ages 13–18. Approximately 52% of victims suffered neglect, 25% physical abuse, 13% sexual abuse, 5% emotional maltreatment, 3% medical neglect, and 14% other forms of maltreatment. Some children suffered multiple types of maltreatment.

Forty-four states reported that a total of 996 children died from abuse or neglect. Available data suggest that the majority (77%) of children dying from abuse and neglect were age 3 or younger and over 40% were infants under the age of 1. The National Child Abuse and Neglect Data System (NCANDS) is the primary source of national information on abused and neglected children known to state child protective services agencies. In 1995, state child protective services agencies received and referred for investigation an estimated 2 million reports alleging the maltreatment of almost 3 million children. Reports were received in almost equal proportions from community professionals and members of the general public (such as friends, relatives, or neighbors of the reported children).

Source: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect. *Child Maltreatment 1995: Reports from the States to the National Child Abuse and Neglect Data System* (Washington, DC: U.S. Government Printing Office, 1997).

PERCENTAGE OF CHILD ABUSE AND NEGLECT VICTIMS BY TYPE OF MALTREATMENT: 1995

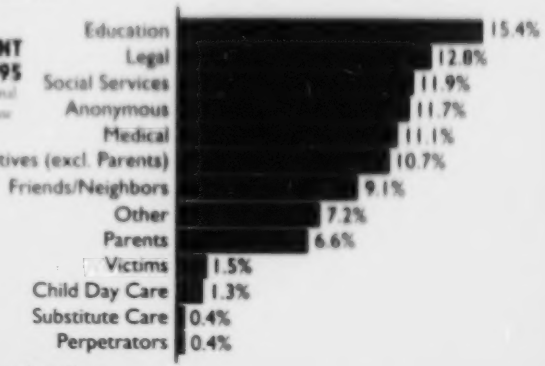
Source (II.16): National Center on Child Abuse and Neglect



Note: Percentage total more than 100% because some states report more than one type of maltreatment per victim. N=1,000,502 victims in 49 States.

SOURCES OF MALTREATMENT REPORTS: 1995

Source (II.17): National Center on Child Abuse and Neglect



Note: 1,485,605 reports from 42 states.

DENTAL CARIES

From 1988-1991, 25% of children ages 5-17 accounted for approximately 80% of children with filled permanent teeth. Furthermore, differences in caries prevalence were found among racial and ethnic subpopulations. Mexican-American children ages 5-17 had the highest prevalence of caries in permanent teeth (48.6%) compared to non-Hispanic whites (44.3%) and non-Hispanic blacks (39.4%).

Most childhood tooth decay is preventable. NHANES III data from 1988-1991 revealed that 17% of childhood dental caries occurred on smooth surfaces and 83% occurred on surfaces with pits and fissures. Fluoride is best at preventing tooth decay on smooth surfaces, while dental sealants (thin plastic coatings applied to the tops of teeth) can prevent decay on the pits and fissures of teeth, particularly on molars.

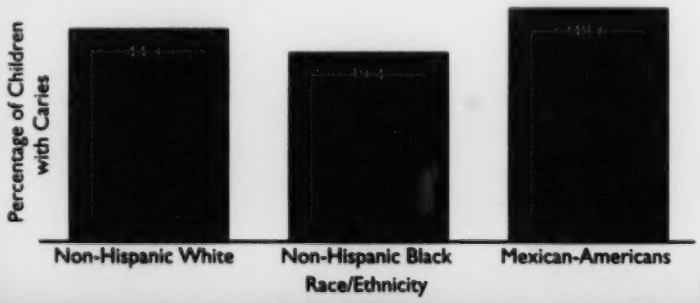
NHANES III data from 1988-1991 revealed that fewer than 30% of U.S. children have dental sealant applied to at least one molar. This proportion is far from the Healthy People 2000 goal of 50% sealant coverage among children. Furthermore, the rate of sealant coverage among white children (27%) is nearly three times higher than that for black (9%) and Hispanic (10%) children 8 years of age.

Permanent molars are the most likely to benefit from sealant application. First molars come in when a child is approximately 6 years old; second molars appear around age 12. Sealants are most effective if they are applied to the molars soon after they have appeared, before teeth have a chance to decay.

Sealants should be used as part of a child's total preventive dental care. However, they are not a substitute for the regular use of fluoride in the water supply and toothpaste. A complete preventive dental program includes the use of sealants, fluoride, plaque removal, careful food choices, and regular dental care.

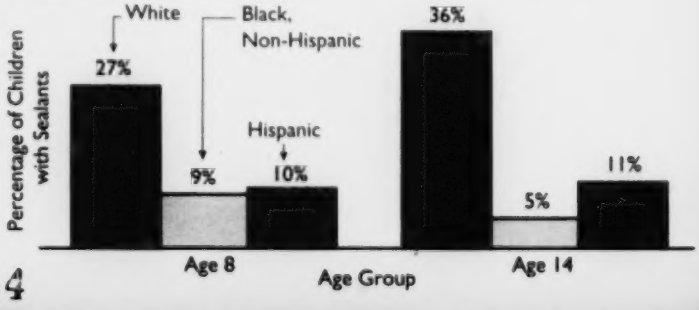
PERCENTAGE OF CHILDREN AGES 5–17 WITH DENTAL CARIES IN PERMANENT TEETH, BY RACE/ETHNICITY: 1988–1991

Source (II.18): National Institutes of Health



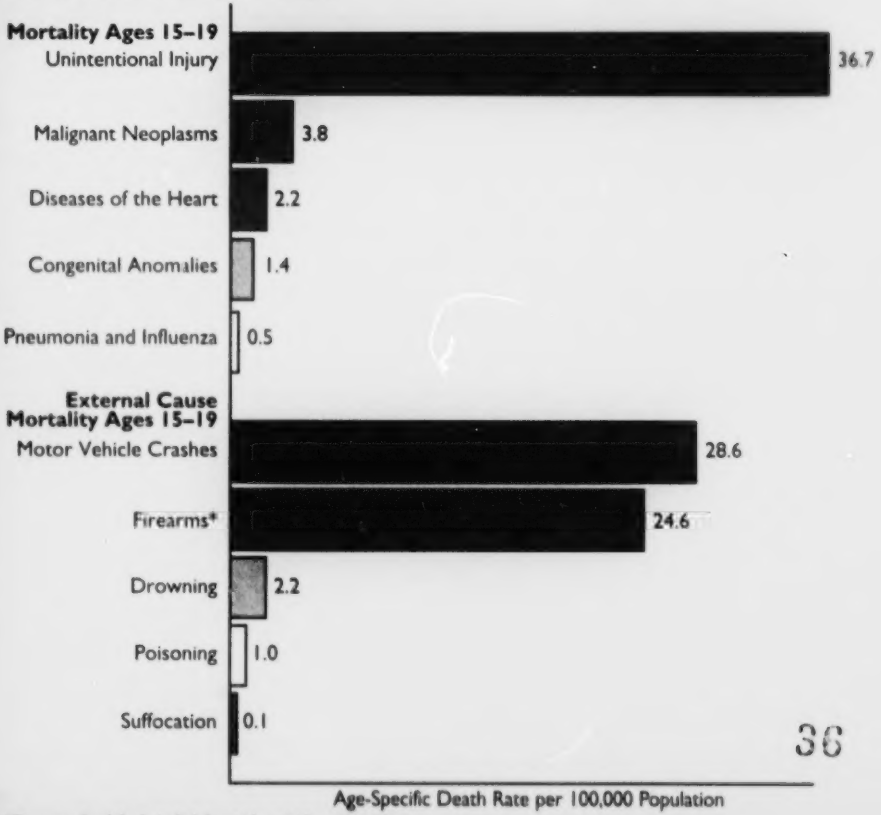
PREVALENCE OF DENTAL SEALANTS IN 8 AND 14 YEAR-OLD CHILDREN: 1988–1991

Source (II.19): National Institutes of Health



BEST COPY AVAILABLE

LEADING CAUSES OF DEATH IN ADOLESCENTS AGES 15–19: 1995
Source (II.20): National Center for Health Statistics



*Firearms-related deaths include homicides, suicides, and accidents.

ADOLESCENT MORTALITY

In 1995, there were 15,089 deaths of adolescents aged 15–19 years. In that age group, injury was the leading cause of death. The 6,623 injury deaths accounted for 44% of all deaths among 15–19 year olds in 1995. Malignant neoplasms (tumors) were the next leading cause of death, accounting for 4.6% of all deaths among 15–19 year olds. Mortality among teenagers declined substantially between 1960 and the early 1980s. There was a moderate increase in mortality among 15–19 year olds in the mid- to late-1980s. The death rate among that age group has been stable since then.

Motor vehicle crashes were the leading causes of injury mortality among 15–19 year olds in 1995, accounting for approximately 78% of all injury deaths among teenagers. The next three leading causes of injury death—suffocation, drowning, and poisoning—each accounted for 2% to 6% of all injury deaths among 15–19 year olds.

ADOLESCENT DEATHS DUE TO INJURY

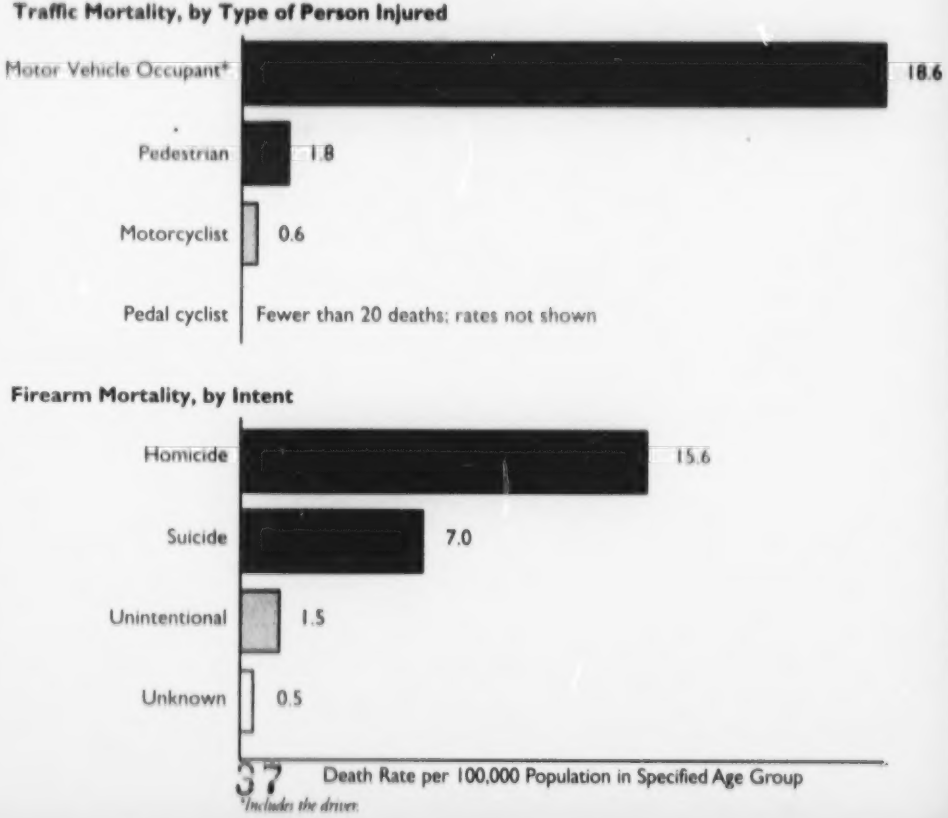
In 1995, motor vehicle traffic crashes caused the death of 5,168 15–19 year olds. Almost 65% of those killed were in motor vehicles, either as passengers or the driver. Deaths of pedestrians, motorcyclists, and others accounted for the remainder of motor vehicle mortality among teenagers.

Results of CDC's 1995 Youth Risk Behavior Surveillance System (YRBSS) survey revealed that in the 30 days preceding the survey, 21.7% of respondents had rarely or never used a safety belt, and 38.8% had ridden with a driver who had been drinking alcohol.

In 1995, 4,432 15–19 year olds were killed by firearms in the U.S. Homicide accounted for 64% of firearm deaths among teenagers, 29% were suicide and 6% were considered to be unintentional. Results of CDC's 1995 YRBSS survey revealed that in the 30 days preceding the survey, 20% of respondents had carried a weapon. In the 12 months prior to the survey, 8.7% of respondents had attempted suicide.

MOTOR VEHICLE CRASHES AND FIREARMS MORTALITY AMONG ADOLESCENTS, AGES 15–19: 1995

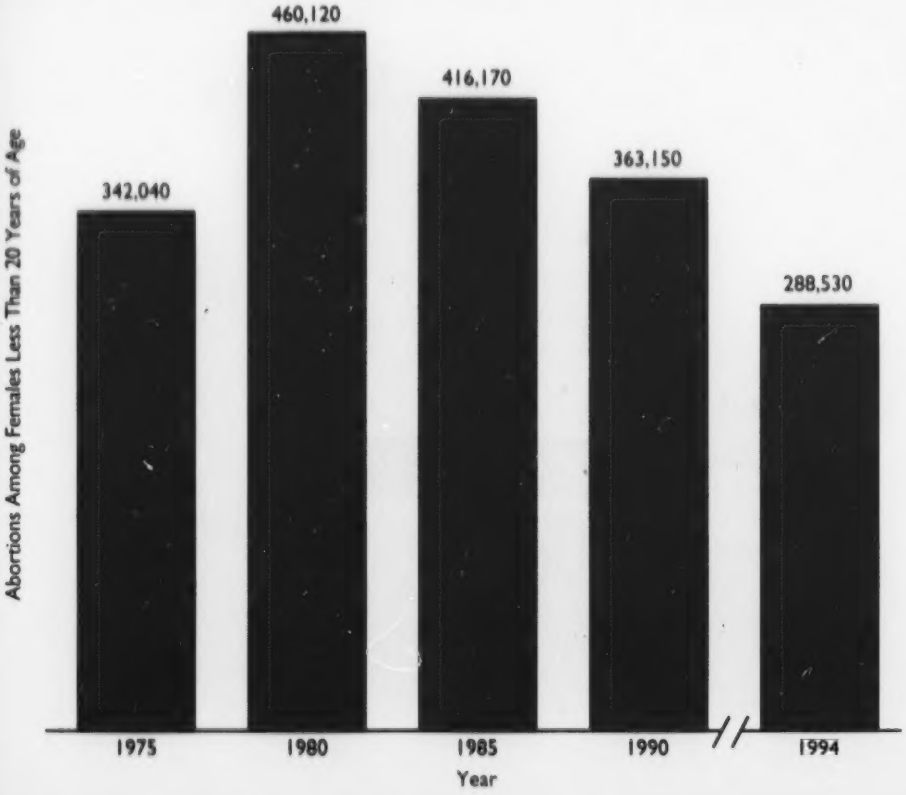
Source (II.21): National Center for Health Statistics



*Includes the driver.

ABORTION TRENDS AMONG WOMEN YOUNGER THAN 20 YEARS OF AGE*: 1971–1994

Source (II.22): The Alan Guttmacher Institute



TEEN PREGNANCY AND ABORTION RATES

In 1994, there were 939,450 pregnanci among women younger than 20 years of ag Pregnancy outcomes included 518,389 li births (55.2%) and 288,530 induced abo tions (30.7%).

Although the number of abortions amon females younger than 20 increased sharply fro 1975 to 1980, the rate has decreased steadi from 1980–1994. While the number of abo tions decreased by 10% from 1980 to 1985, decreased by over 20% from 1990 to 1994.

Researchers consistently find four broad fa tors that predict sexual intercourse at an ear age, adolescent pregnancy and nonmarit childbearing among teenagers: school failur early behavior problems, poverty, and fami problems/family dysfunction.

**Data represent a woman's age at the time a pregnancy end More pregnancies were experienced by teenagers than were repo ed because most of the 19 year-olds who became pregnant h their births or abortions at age 20 and thus were not counted.*

SEXUAL INTERCOURSE

Among high school students in the U.S., the percentage of students in 9th through 12th grades reporting ever having had sexual intercourse increased significantly by grade. Overall, black students were significantly more likely than white and Hispanic students to have had sexual intercourse.

Nearly 50% of students in the 12th grade reported having had sexual intercourse during the preceding three months. The prevalence rate of sexual activity increased significantly from grades 9 through 12 among both females (22.3% to 51.9%) and males (24.2% to 47.9%). Overall, male students were significantly more likely than female students (20.9% versus 14.4%) to have had four or more sex partners during their lifetime.

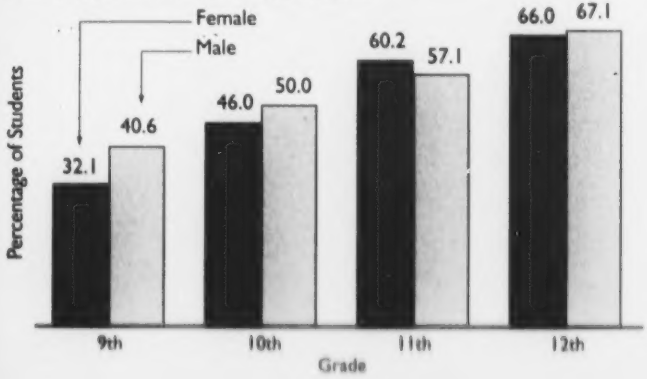
CONDOM USE

More than half (54.4%) of sexually active 9th through 12th graders reported condom use during last sexual intercourse. Males were significantly more likely than females to have reported that a condom was used.

While sexual activity increased by grade for all students, condom use decreased by grade. Only 49% of sexually active 12th graders reported condom use, compared with 62.9% of sexually active 9th graders.

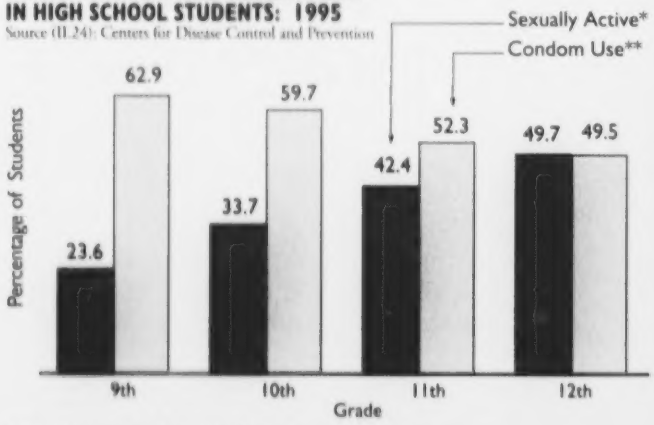
PERCENTAGE OF HIGH SCHOOL STUDENTS WHO HAVE EVER HAD SEXUAL INTERCOURSE, BY GRADE AND GENDER: 1995

Source (II.23): Centers for Disease Control and Prevention



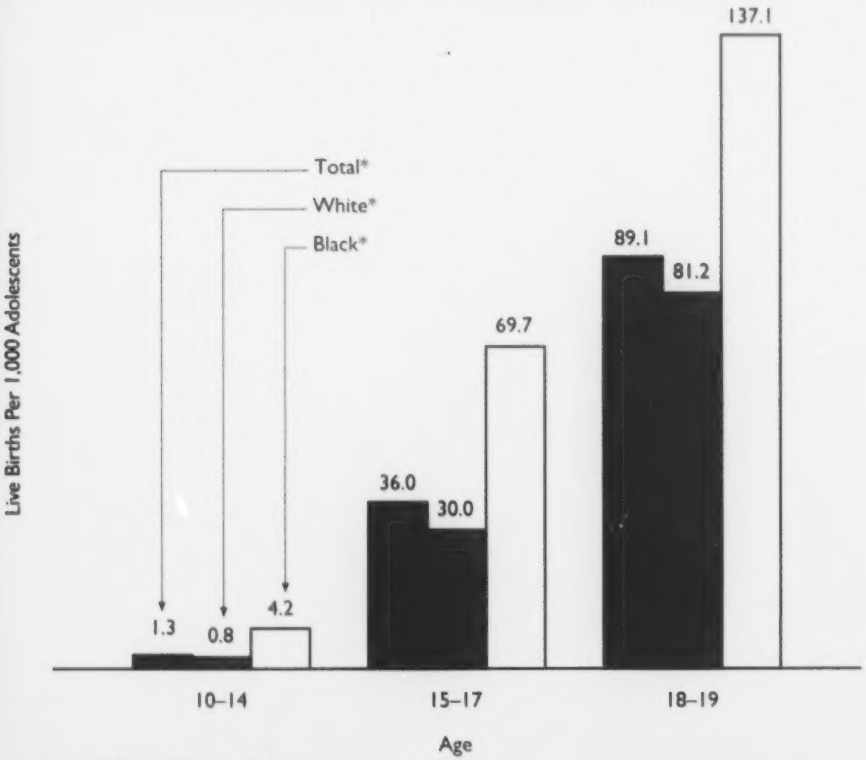
SEXUAL ACTIVITY AND CONDOM USE IN HIGH SCHOOL STUDENTS: 1995

Source (II.24): Centers for Disease Control and Prevention



* *Sexual intercourse during the 3 months preceding the survey.*
** *Among sexually active students at last sexual intercourse.*

LIVE BIRTHS AMONG ADOLESCENTS, BY AGE AND RACE OF MOTHER: 1995
Source (II.25): National Center for Health Statistics



*Includes the ethnic classification of Hispanic.

ADOLESCENT CHILDBEARING

In 1995, the live birth rate per 1,000 adolescent females was 1.3 for ages 10–14, 36.0 for those 15–17, and 89.1 for those 18–19 years old.

In 1995, there were 65,039 live births among black females younger than 18 years of age, which represented 10.8% of all births to black women. There were 133,019 births to white females under 18, which represented 4.3% of all births to white women.

In 1995, approximately 59 million women were of childbearing age (15–44 years) in the United States.

OLESCENT AIDS

of December 31, 1996, 2,754 cases[1] of S were reported in adolescents aged 13–19 . This total includes 403 newly reported in 1996.

hites comprised 34% of the AIDS cases ng adolescents. Of these, 62% were exposed IV primarily through receipt of clotting r for hemophilia/coagulation disorder or as ult of blood transfusions. Eighteen percent hites aged 13–19 years were exposed to HIV gh male-to-male sexual contact.

rty-six percent of adolescent AIDS cases among black, non-Hispanics. Twenty-six nt of blacks aged 13-19 were exposed to through male-to-male sexual contact.

January 1, 1993, the AIDS case definition for adults and adolescents aged 13 years and older was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/ul, or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

Receipt of Blood/Blood components:

[2] Received clotting factor for hemophilia coagulation disorder.

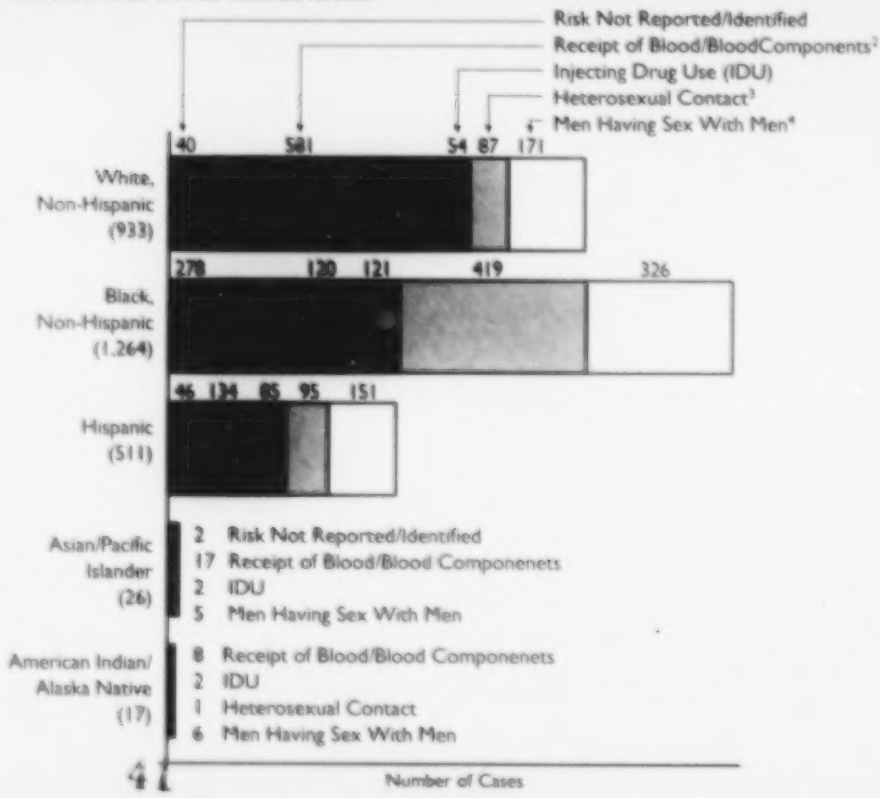
[3] Received blood transfusion, blood components, or tissue.

Heterosexual contact includes sex with: an injecting drug user, a person with hemophilia, a transfusion recipient infected with HIV, an HIV infected person, risk not specified, a bisexual male (females only).

[4] The category "Men Who Have Sex with Men" includes men who have sex with men and also inject drugs.

ADOLESCENT AIDS CASES BY RACE/ETHNICITY AND EXPOSURE CATEGORY FOR AGES 13–19: 1981–1996

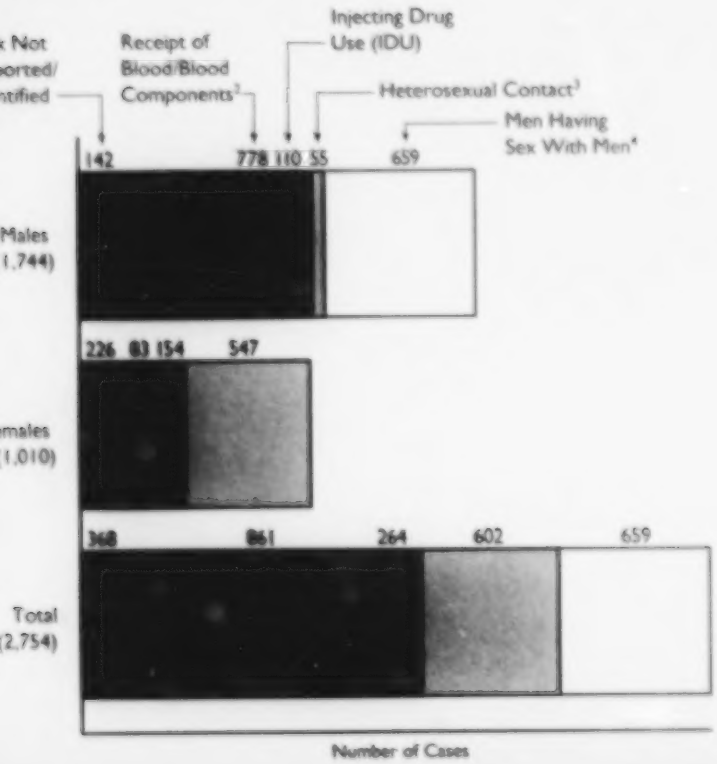
Source: (II.26) Centers for Disease Control and Prevention



Note: Race is unknown for 3 persons in this age group, therefore a total of 2,751 cases are represented in the graph.

LESCENT AIDS CASES BY GENDER AND EXPOSURE CATEGORY FOR AGES 13–19: 1–1996

(II.27) Centers for Disease Control and Prevention



ADOLESCENT AIDS

Males comprised 63% of the 2,354 AIDS cases[1] among adolescents aged 13-19 years. These young men were exposed to HIV primarily through receipt of clotting factor for hemophilia/coagulation disorder or as a result of blood transfusions. Thirty-eight percent of males aged 13-19 years were exposed to HIV through sexual contact with other males.

Thirty-seven percent of adolescent AIDS cases were among females. Of those, 54% acquired HIV infection through heterosexual contact. Twenty-two percent had sex partners who were injecting drug users, while 15% were injecting drug users themselves.

Notes

1. *On January 1, 1993, the AIDS case definition for adults and adolescents, aged 13 years and older was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/ml or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.*
2. *Receipt of Blood/Blood components:*
   - *Received clotting factor for hemophilia/coagulation disorder*
   - *Received blood transfusion, blood components, or tissue*
3. *Heterosexual contact include sex with: an injecting drug user, a person with hemophilia, a transfusion recipient infected with HIV, an HIV-infected person, risk not specified, a bisexual male (female only).*
4. *The category "Men Who Have Sex with Men" includes men who have sex with men and also inject drugs.*

OUNG ADULT AIDS

s of December 31, 1996, 21,097 cases[1] of
DS were reported in young adults aged 20-24
rs. This total includes 2,171 newly reported
s in 1996. The number of newly reported
s decreased by nearly 11% from 1995 to 1996.
cross all racial/ethnic groups, men who have
with men is the major exposure category asso-
ed with known AIDS cases in young adults.
ng adult women (25% of known AIDS cases
his age group) are exposed to HIV primarily
ugh injecting drug use (30%) or through sex
an injecting drug user (24%).

On January 1, 1993, the AIDS case definition for adults and adolescents, aged 13 years and older, was expanded to include HIV-infected persons with CD4 counts of less than or equal to 200 cells/ml, or a CD4 percentage of less than or equal to 14, and persons diagnosed with pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.

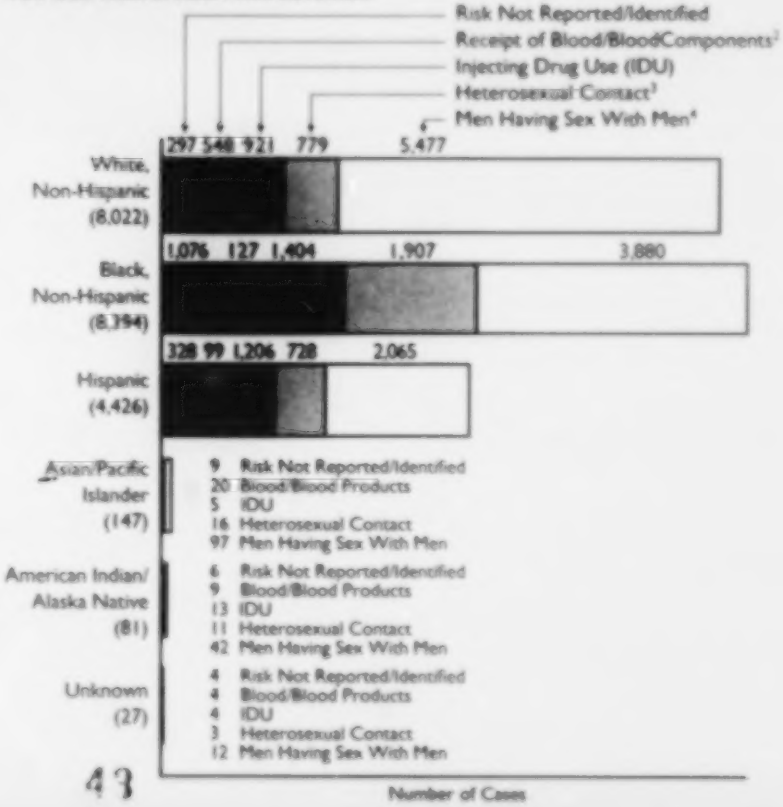
[2]Receipt of Blood/Blood components:
- *Received clotting factor for hemophilia coagulation disorder*
- *Received blood transfusion, blood components, or tissue*

[3]Heterosexual contact includes sex with: an injecting drug user, a person with hemophilia, a transfusion recipient infected with HIV, an HIV-infected person, risk not specified, a bisexual male (females only).

[4]The category "Men Who Have Sex with Men" includes men who have sex with men and also inject drugs.

YOUNG ADULT AIDS CASES BY RACE/ETHNICITY AND EXPOSURE CATEGORY FOR AGES 20–24: 1981–1996

Source (II.28): Centers for Disease Control and Prevention



43

SUBSTANCE ABUSE

Trends in Thirty Day Prevalence

Preliminary results of the Substance Abuse and Mental Health Services Administration's 1996 National Household Survey on Drug Abuse show that the percentage of adolescents ages 12 - 17 who reported using illicit drugs[1], specifically alcohol, marijuana, and cocaine, in the month prior to the survey decreased from 1995 to 1996. The rate of adolescent use for all illicit drugs declined from 10.9% in 1995 to 9.0% in 1996.

Alcohol use among 12 to 17 year-olds declined significantly from 21.1% in 1995 to 18.8% in 1996. This encouraging downward trend in use began in 1993.

Although the rate of marijuana use by teens remained statistically unchanged, falling slightly from 8.2% to 7.1%, the decline indicates a possible shift in the trend that has shown marijuana use among adolescents double from 1992 to 1995. Although marijuana use has dropped a bit, cocaine use may be inching back up, and heroin use is definitely increasing. The use of hallucinogens is also continuing on an upward trend.

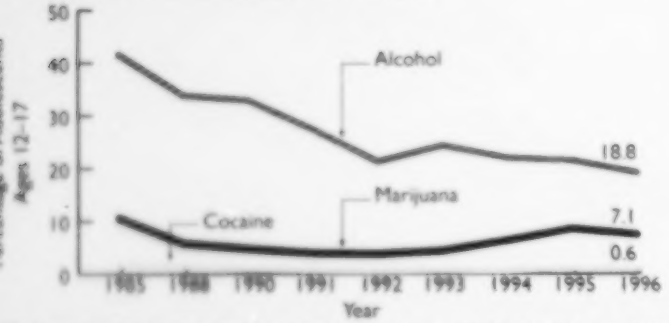
Perception of Risk and Access to Drugs

There was no change in perceived risk of marijuana use among adolescents ages 12-17 between 1994 and 1996. Furthermore, more teenagers are trying heroin for the first time, and children's perception of cocaine as risky is down.

More than half of the adolescents surveyed reported that marijuana was easy to obtain in 1996, and about one quarter reported that heroin was easy to obtain. Fifteen percent of respondents reported being approached by someone selling drugs in the month prior to the survey.

LONG-TERM TRENDS IN THIRTY-DAY PREVALENCE OF USE OF VARIOUS TYPES OF DRUGS AMONG ADOLESCENTS AGES 12–17: 1985–1996

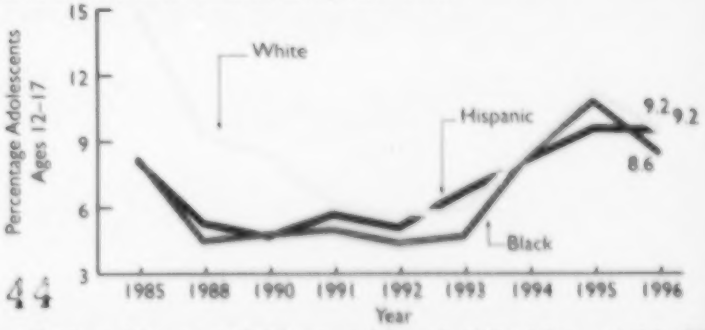
Source (II.29): National Household Survey on Drug Abuse, SAMHSA



The National Household Survey on Drug Abuse is based on a representative sample of the U.S. population aged 12 and older, including persons living in households and in some group quarters such as dormitories and homeless shelters.

LONG-TERM TRENDS IN THIRTY-DAY PREVALENCE OF USE OF ANY ILLICIT DRUG AMONG ADOLESCENTS AGES 12–17, BY RACE/ETHNICITY: 1985–1996

Source (II.30): National Household Survey on Drug Abuse, SAMHSA



2 Illicit drugs include marijuana or hashish, cocaine (including crack), inhalants, hallucinogens (including PCP and LSD), heroin, or any prescription-type psychotherapeutic used non-medically.

CIGARETTE SMOKING

Trends in Thirty Day Prevalence

The University of Michigan's Institute for Social Research found that cigarette smoking rose again in 1996 among American youth. This is the fifth year in a row that cigarette smoking increased for 8th and 10th graders, and the fourth year in a row for high school seniors. Thirty-four percent of high school seniors said that they had smoked cigarettes 30 days prior to the survey. This represents an increase of 0.5% from 1995.

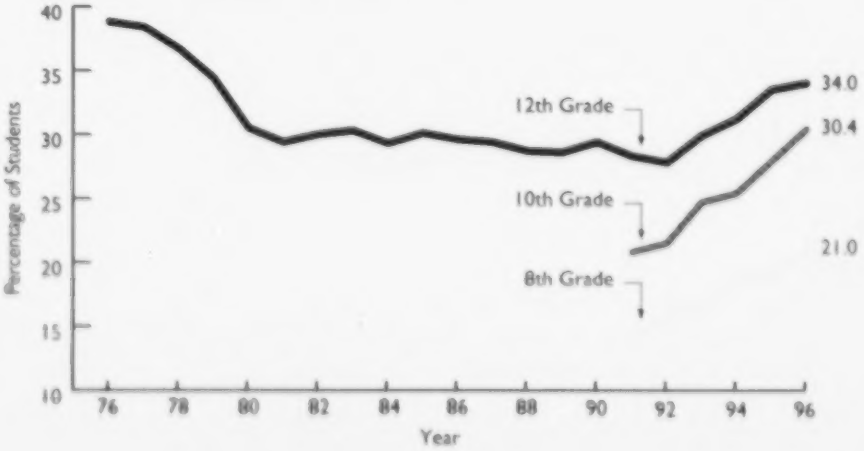
Increased smoking rates will have severe, lifelong consequences for this generation because a large proportion of those who initiate smoking in adolescence will continue to smoke for the rest of their lives.

Substantial increases in smoking have been occurring in virtually every sociodemographic group: among boys and girls, among those bound for college and those not, among respondents in all regions of the country and in urban and rural areas, among socioeconomic levels, and among whites, blacks, and Hispanics.

There are, however, some subgroup differences in smoking rates: respondents without future college plans were more likely to smoke than those who had such plans; those growing up in the South were somewhat less likely to smoke than those growing up in other regions of the country; and African American youth were substantially less likely to smoke than white youth.

LONG-TERM TRENDS IN THIRTY-DAY PREVALENCE OF CIGARETTE SMOKING FOR 8TH, 10TH, AND 12TH GRADERS: 1976-1996

Source (II.51): The Monitoring the Future Study, University of Michigan



YSICAL ACTIVITY D OVERWEIGHT

he 1995 Youth Risk Behavior Surveillance em Survey (YRBSS) revealed that over of 9th through 12th grade students ght that they were overweight, and over were attempting weight loss. Results of third National Health and Nutrition ination Survey (NHANES III: 1988-) indicate that 12% of adolescents ages 17 are actually overweight.

male students were significantly more like- an male students to be attempting weight 59.8% versus 24.3%), as were white and anic students as opposed to black students. ly one third of all students had dieted either to lose weight or to keep from gaining weight during the 30 days preceding the survey. Over 50% of students had exercised either to lose weight or to keep from gaining weight.

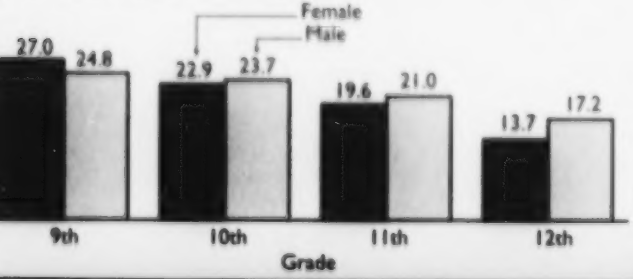
Results of the YRBSS show that nearly two thirds of students participate regularly in vigorous[1] physical activity and more than one fifth regularly participate in moderate[2] physical activity. Furthermore, 50% of the students do regular strengthening[3] exercises. Nationwide, nearly 60% of students were enrolled in a physical education class, but students in 9th grade were significantly more likely to be enrolled than students in 11th and 12th grades.

Diet and physical activity are the two primary behavioral factors believed to be associated with becoming overweight. In July 1996, Audrey F. Manley, M.D., M.P.H., the acting Surgeon General, released *Physical Activity and Health: A Report of the Surgeon General.* The report outlined the significant health benefits of regular, moderate physical activity. One of the report's major conclusions is that moderate activity helps to combat the risk of developing various diseases and chronic conditions.

1 *Activities that caused sweating and hard breathing for at least 20 minutes on ≥3 of the preceding 7 days.*
2 *Walked or bicycled for at least 30 minutes on ≥5 of the 7 days preceding the survey.*
3 *Such as push-ups, sit-ups, or weight lifting on ≥3 of the 7 days preceding the survey.*

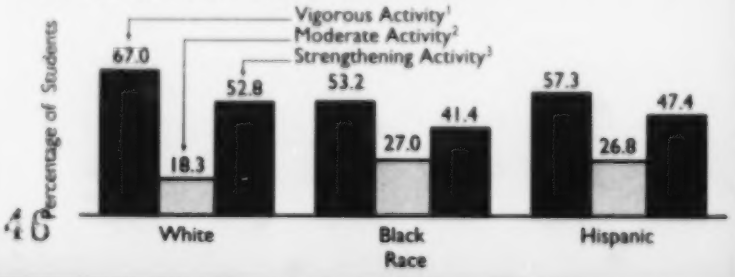
ENTAGE OF HIGH SCHOOL STUDENTS WHO PARTICIPATED IN ERATE PHYSICAL ACTIVITY, BY GRADE: 1995

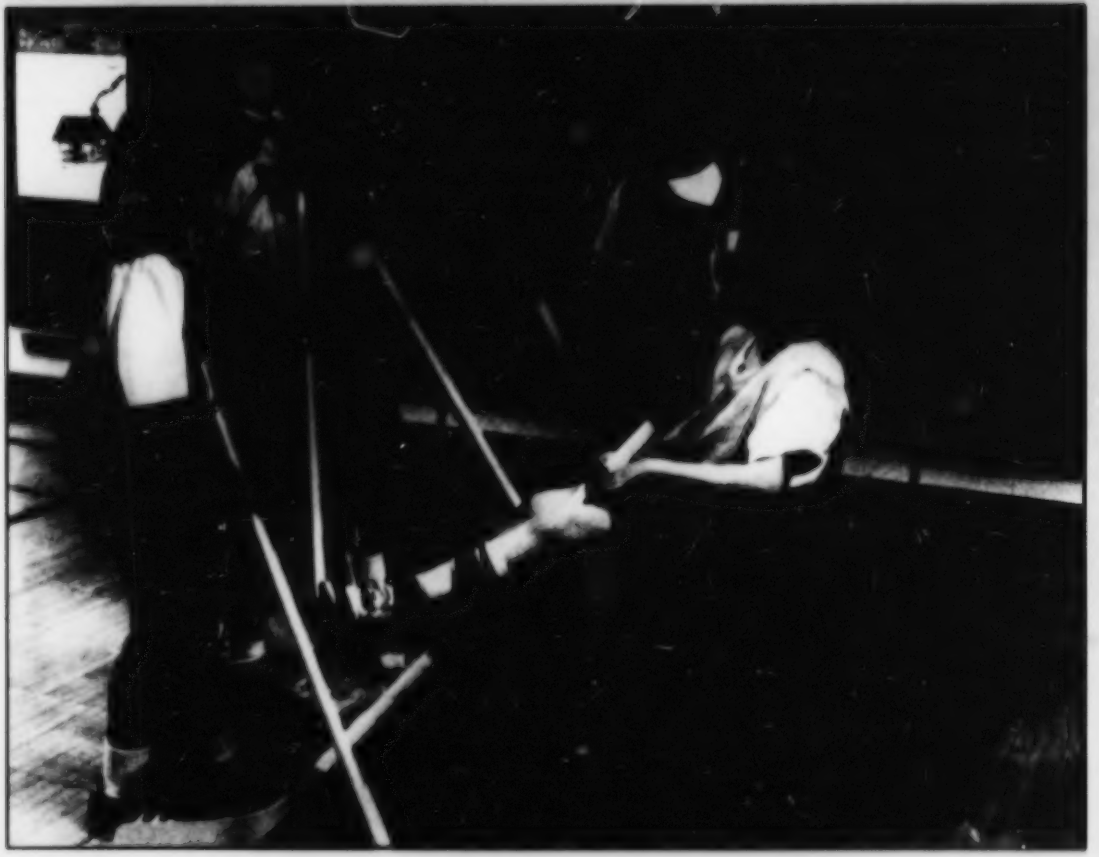
(II.32): Centers for Disease Control and Prevention

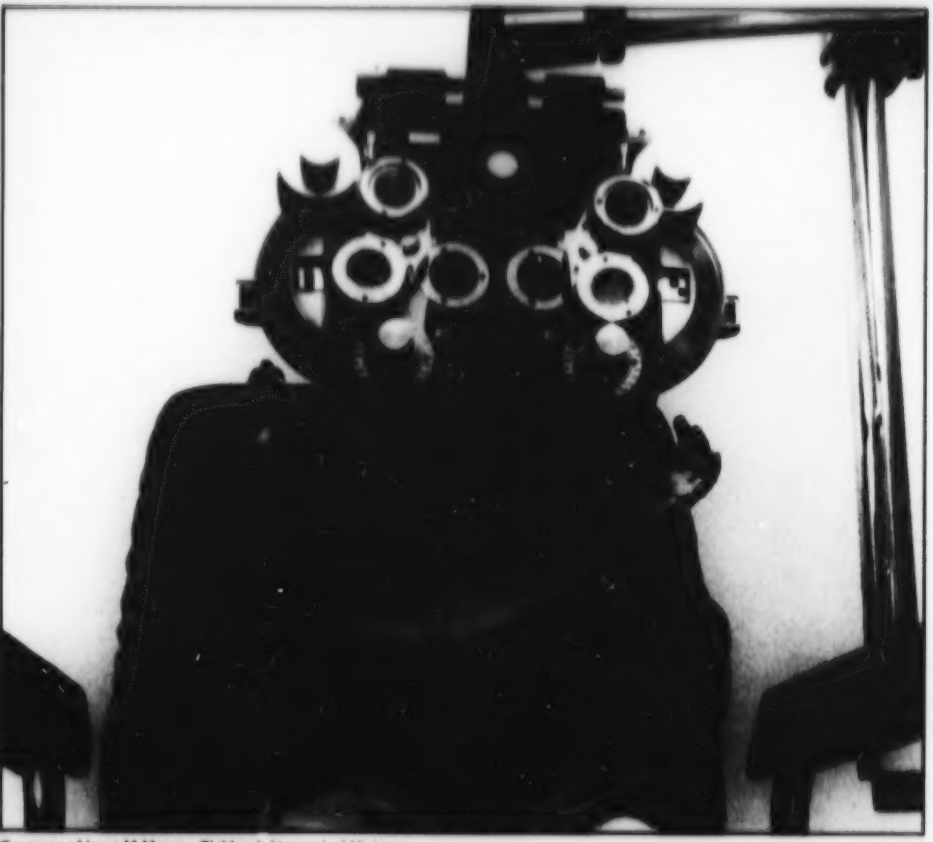


PERCENTAGE OF HIGH SCHOOL STUDENTS WHO PARTICIPATED IN VIGOROUS, MODERATE, OR STRENGTHENING PHYSICAL ACTIVITY, BY RACE: 1995

Source (II.33): Centers for Disease Control and Prevention







Courtesy of Janet McManan, Children's Hospital of Michigan

HEALTH SERVICES AND UTILIZATION

The availability of, and access to, quality health care directly affect the health of mothers and children, especially those at high risk due to chronic medical conditions or low socio-economic status. As more mothers and children become enrolled in Medicaid managed care, monitoring quality assurance has become, and will continue to be, increasingly important.

New Federal legislation includes provisions to expand health insurance coverage to the estimated 10 million uninsured children in the U.S. An estimated 3 million of those 10 million children are eligible for Medicaid but are not enrolled. Outreach and consumer education will therefore be key components of the expansion of health insurance coverage for children.

The following section presents data on the utilization of health services within the maternal and child population. The most current data are summarized by source of payment, type of care, and place of service delivery. Data are presented by age, ethnicity, and income.

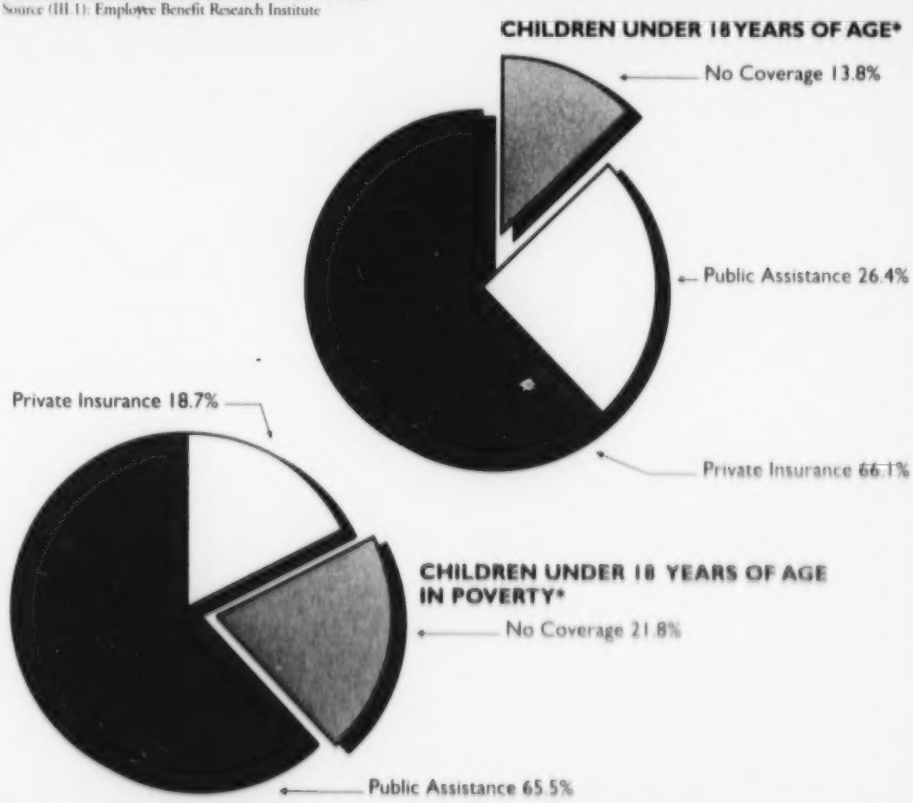
HEALTH CARE FINANCING

A 1996 report from the Employee Benefit Research Institute indicated that 13.8%, or 9.8 million children younger than 18 years of age, had no insurance coverage in 1995. During the course of the year fewer than half (44.8%) of uninsured preschool children had any well-child visits, and uninsured preschoolers were less likely than insured ones to be fully immunized.

Of those children with insurance, 26.4% were publicly insured, primarily through Medicaid, and 66.1% were covered by private insurance. Most privately insured children (89%) received insurance through their parents' employer, but such coverage, when available, was increasingly expensive and required parental copayments.

Of children younger than 18 whose families lived in poverty, 65.5% were publicly insured and 18.7% had private coverage. However, 21.8% of children in poverty had no health coverage in 1995. Nearly 30% of uninsured children are eligible for Medicaid, but are not enrolled in the program. In 1995, an estimated 80.3% of uninsured children lived in families that had at least one parent who worked part-time or full-time, for all or part of the year.

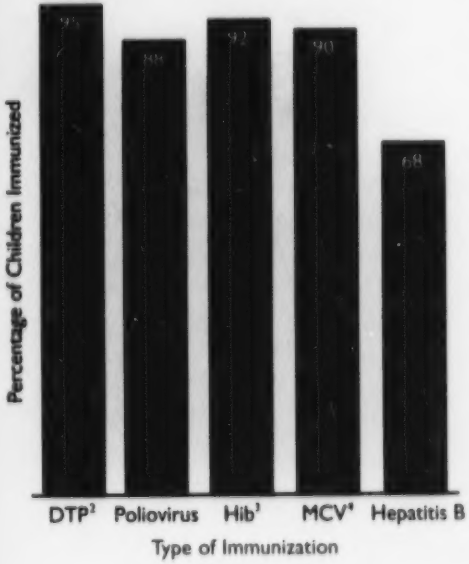
HEALTH INSURANCE COVERAGE: 1995
Source (III.1): Employee Benefit Research Institute


CHILDREN UNDER 18 YEARS OF AGE*
No Coverage 13.8%
Public Assistance 26.4%
Private Insurance 66.1%
Private Insurance 18.7%
CHILDREN UNDER 18 YEARS OF AGE IN POVERTY*
No Coverage 21.8%
Public Assistance 65.5%

** Details may add to more than 100% because individuals may receive coverage from more than one source.*

VACCINATION COVERAGE LEVELS AMONG CHILDREN AGED 19–35 MONTHS, BY SELECTED VACCINES: 1995[1]

Source (III.2): Centers for Disease Control and Prevention



1 *Data are from January through December 1995.*
2 *DTP: Diptheria and Tetanus toxoids and pertussis vaccine, ≥3 doses.*
3 *Hib: Haemophilus influenzae type b ≥3 doses.*
4 *MCV: Reflects any measles-containing vaccine, ≥1 dose.*

VACCINATION COVERAGE LEVELS

The Year 2000 objective for the complete series of routinely recommended childhood vaccinations is at least 90% series-complete coverage. Recently released data from CDC's 1995 National Immunization Survey revealed the highest immunization coverage ever recorded. The number of reported cases of diptheria, tetanus, mumps, measles, rubella, poliomyelitis, and *H. influenzae* were at or near record low levels.

However, nearly one million children still need one or more of the recommended doses of a series vaccine to be fully protected. Coverage in state and urban areas varies, and therefore has not reached the national coverage level in some instances.

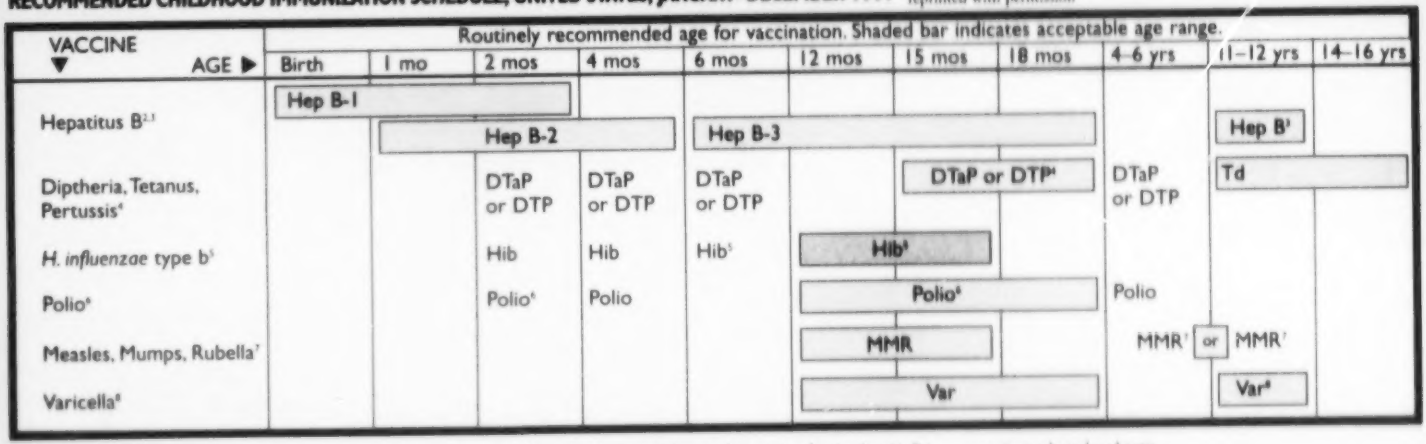
In January 1997, CDC published an updated childhood immunization schedule (see facing page). CDC has also been disseminating a revised polio Vaccine Information Statement. There are two kinds of polio vaccine: Inactivated (IPV), given as a shot, and Oral (OPV). Since it was licensed in 1963, OPV has been used primarily in place of IPV. However, a vaccine schedule using a sequential combination of the two is now recommended: 2 shots of IPV followed by 2 doses of OPV. There are advantages and disadvantages to taking 4 shots of IPV or 4 doses of OPV. Furthermore, OPV alone is contraindicated for children with certain existing health conditions.

An additional vaccination recommendation was issued by CDC in early 1996: a new, FDA-approved varicella (chicken pox) vaccine. At the end of the third quarter of 1996, coverage levels were approximately 15%.

The recent licensure of combination and single antigen vaccines will further challenge the vaccine delivery system. To maintain high coverage levels among children in the population, additional components of the system need to be developed. These include: 1) linkages between each child and an accountable primary care provider; 2) computerized vaccination registries including both public and private providers; 3) means for ensuring financial access to vaccines; and 4) mechanisms for educating parents about the importance of vaccines and educating providers about changes in recommendations.

RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE, UNITED STATES, JANUARY–DECEMBER 1997

Source (III.3): Centers for Disease Control and Prevention (CDC); reprinted with permission



[1] This schedule indicates the recommended age for routine administration of currently licensed childhood vaccines. Some combination vaccines are available and may be used whenever administration of all components of the vaccine is indicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

[2] ***Infants born to HBsAg-negative mothers*** should receive 2.5ug of Merck vaccine (Recombivax HB®) or 10ug of SmithKline Beecham (SB) vaccine (Engerix-B®). The 2nd dose should be administered ≥1 mo after the 1st dose.

Infants born to HBsAg-positive mothers should receive 0.5 mL hepatitis B immune globulin (HBIG) within 12 hrs of birth, and either 5ug of Merck vaccine (Recombivax HB®) or 10ug of SB vaccine (Engerix-B®) at a separate site. The 2nd dose is recommended at 1-2 mos of age and the 3rd dose at 6 mos of age.

Infants born to mothers whose HBsAg status is unknown should receive either 5ug of Merck vaccine (Recombivax HB®) or 10ug of SB vaccine (Engerix-B®) within 12 hrs of birth. The 2nd dose of vaccine is recommended at 1 mo of age and the 3rd dose at 6 mos of age. Blood should be drawn at the time of delivery to determine the mother HBsAg status; if it is positive, the infant should receive HBIG as soon as possible (no later than 1 wk of age). The dosage and timing of subsequent vaccine doses should be based upon the mother's HBsAg status.

[3] Children and adolescents who have not been vaccinated against hepatitis B in infancy may begin the series during any childhood visit. Those who have not previously received 3 doses of hepatitis B vaccine should initiate or complete the series during the 11-12 year-old visit. The 2nd dose should be administered at least 1 mo after the 1st dose, and the 3rd dose should be administered al least 4 mos after the 1st dose, and at least 2 mos after the 2nd dose.

[4] DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is the preferred vaccine for all doses in the vaccination series, including completion of the series in children who have received ≥1 dose of whole-cell DTP vaccine. Whole-cell DTP is an acceptable alternative to DTaP. The 4th dose of DTaP may be administered as early as 12 mos of age, provided 6 mos have elapsed since the 3rd dose, and if the child is considered unlikely to return at 15-18 mos of age. Td (tetanus and diphtheria toxoids, adsorbed, for adult use) is recommended at 11-12 yrs of age if at least 5 yrs have elapsed since the last dose of DTP, DTaP, or DT. Subsequent *routine* Td boosters are recommended every 10 yrs.

[5] Three *H. influenzae* type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® [Merck]) is administered at 2 and 4 mos of age, a dose at 6 mos is not required. After completing the primary series, any Hib conjugate vaccine may be used as a booster.

[6] Two poliovirus vaccines are currently licensed in the US: inactivated poliovirus vaccine (IPV) and oral poliovirus vaccine (OPV). The following schedules are all acceptable by the ACIP, the AAP, and the AAFP, and parents and providers may choose among them:

1. IPV at 2 and 4 mos; OPV at 12-18 mos and 4-6 yrs
2. IPV at 2, 4, 12-18 mos, and 4-6 yrs
3. OPV at 2, 4, 6-18 mos, and 4-6 yrs

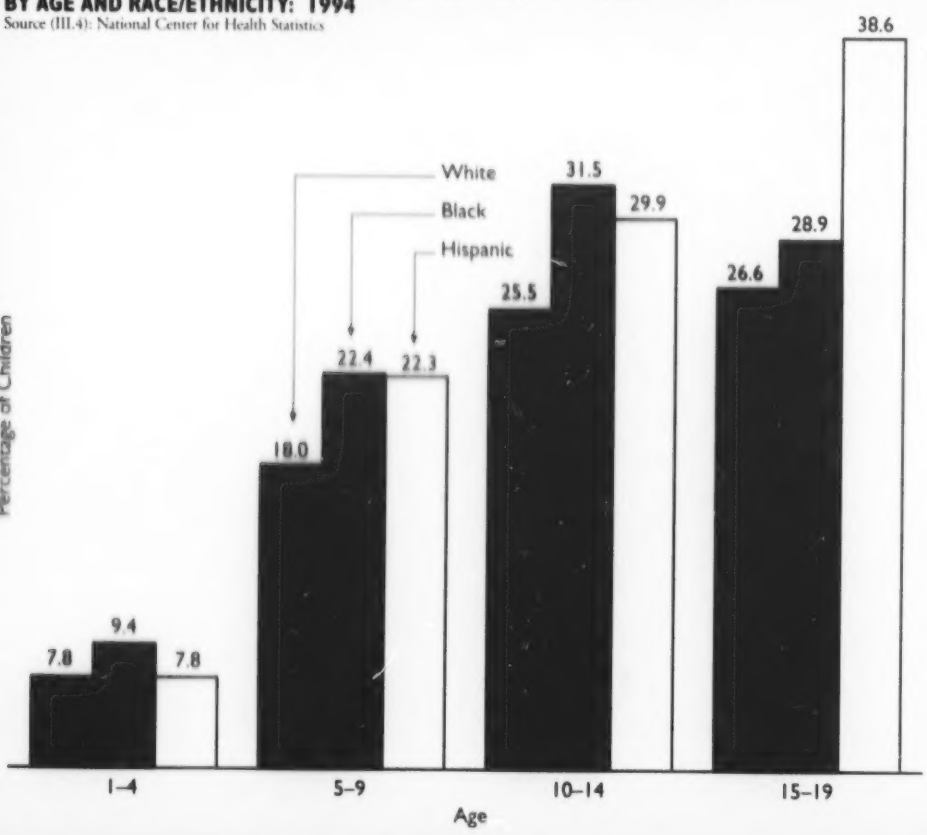
The ACIP routinely recommends schedule 1. IPV is the only poliovirus vaccine recommended for immunocompromised persons and their household contacts.

[7] The 2nd dose of MMR is routinely recommended at 4-6 yrs of age or at 11-12 yrs of age, but may be administered during any visit provided at least 1 mo has elapsed since receipt of the 1st dose, and that both doses are administered at or after 12 mos of age.

[8] Susceptible children may receive Vericella vaccine (Var) during any visit after the 1st birthday, and unvaccinated persons who lack a reliable history of chickenpox should be vaccinated during the 11-12 year-old visit. Susceptible persons ≥13 yrs of age should receive 2 doses, at least 1 mo apart.

PERCENTAGE OF CHILDREN WITH NO PHYSICIAN VISITS IN THE PAST YEAR, BY AGE AND RACE/ETHNICITY: 1994

Source (III.4): National Center for Health Statistics



PHYSICIAN VISITS

In 1994, nearly 20.7% of children younger than 20 years of age, or 15.5 million children, were not seen by a physician in the past year. In all age groups, a higher percentage of black children than white children had not been seen by a physician in the past year.

During 1994, 7.8% of white, 9.4% of black, and 7.8% of Hispanic origin children ages 1–4 were not seen by a physician.

PLACE OF PHYSICIAN CONTACT

Among children who saw a physician during the past year, children younger than 5 years old averaged more physician contacts than school-age children.

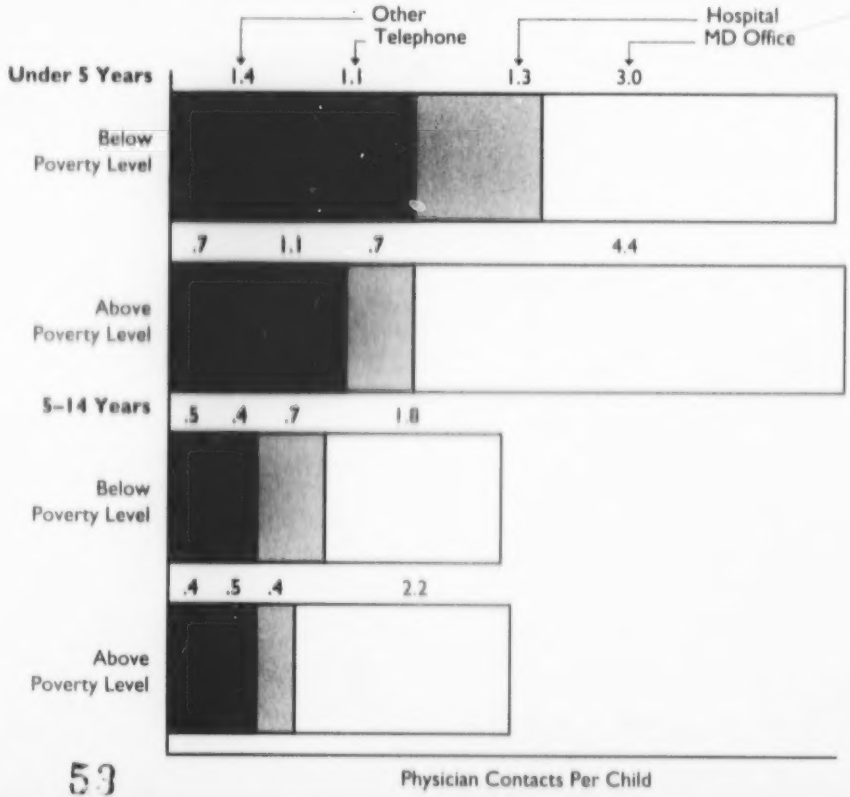
Children whose family income was above the poverty level used more physician services than children in poverty.

Children in poverty were more likely to see physicians in hospitals and places other than physicians' offices than children above poverty.

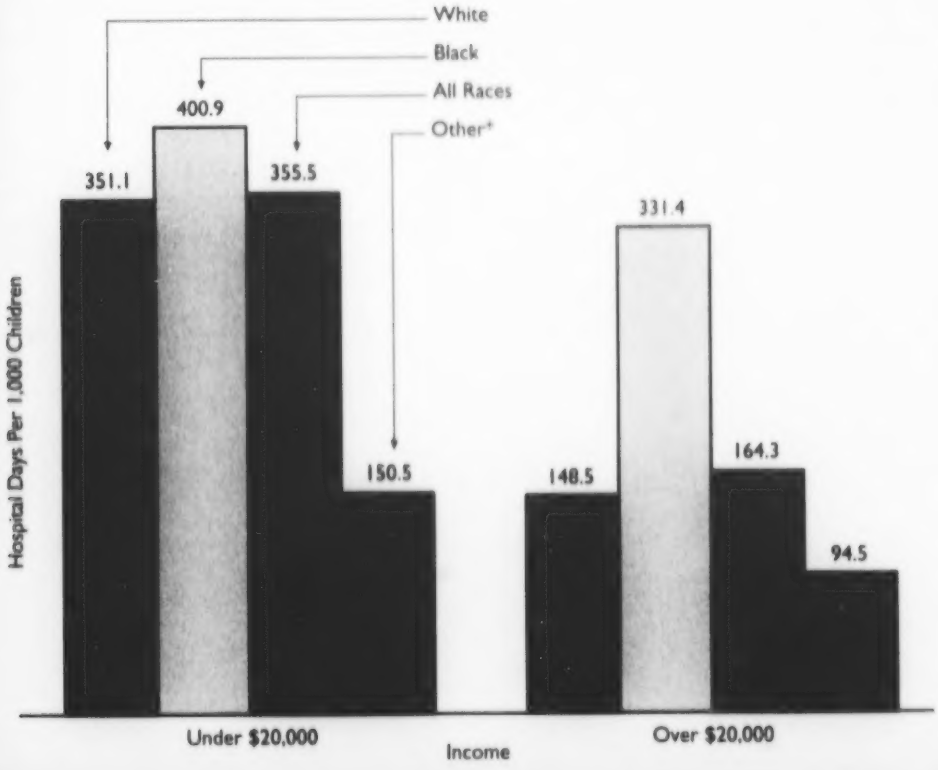
However, from 1993 to 1994, the number of physician contacts per child in a physician's office increased for children aged 5–14 years in poverty, while it decreased for children younger than 5 years old in poverty.

PLACE OF PHYSICIAN CONTACT BY AGE AND POVERTY STATUS: 1994

Source (III 5): National Center for Health Statistics



HOSPITAL UTILIZATION BY INCOME AND RACE: 1994
Source (III.6): National Center for Health Statistics



HOSPITAL UTILIZATION

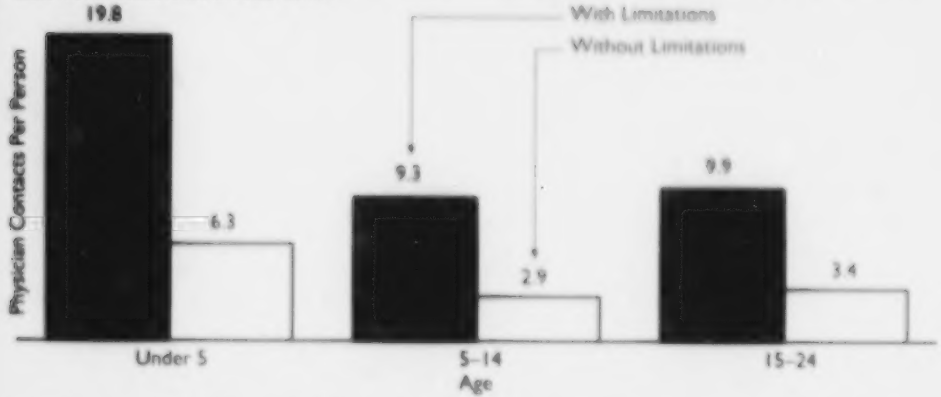
In 1994, children younger than age 18 in families with incomes less than $20,000 averaged 1.5 times more hospital days per 1,000 children than children from higher income families.

Regardless of income status, black children younger than 18 years of age had the highest number of hospital days per 1,000 children.

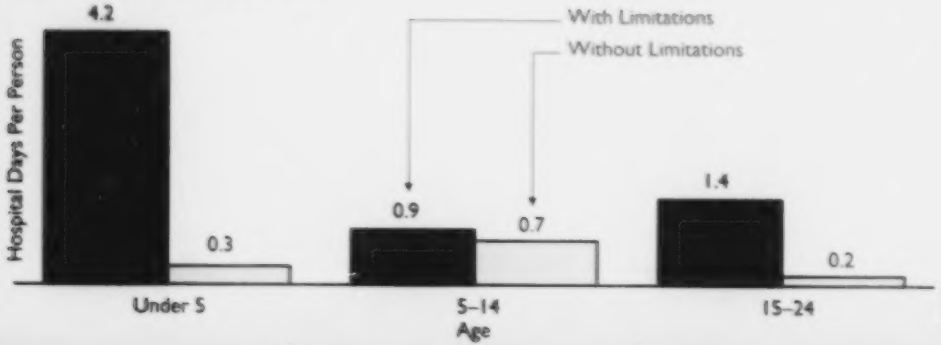
Other includes:
Indian (American)
Eskimo
Aleut
Chinese
Filipino
Hawaiian
Korean
Vietnamese
Japanese
Asian Indian
Samoan
Guamanian
Other Asian Pacific Islanders
Other Race
Multiple Race
Unknown

Courtesy of Children's Hospital of Wisconsin

PHYSICIAN UTILIZATION BY CHILDREN WITH CHRONIC ACTIVITY LIMITATIONS, BY AGE: 1994
Source (III.7): National Center for Health Statistics



HOSPITAL UTILIZATION BY CHILDREN WITH CHRONIC ACTIVITY LIMITATIONS, BY AGE: 1994 (EXCLUDING DELIVERIES)
Source (III.8): National Center for Health Statistics



SERVICE UTILIZATION BY CHILDREN WITH CHRONIC CONDITIONS

Physician Utilization

In 1994, children who were limited in activities* had three times as many physician contacts as children without chronic conditions.** The number of physician contacts per person for ages 15 to 24 remained stable from 1993 to 1994, while it decreased for all others.

Hospital Utilization

Children with chronic conditions spend about 10 times as many days in the hospital as children without activity limitations.

* *Limitation of activity is defined as the inability to participate in ordinary play for children less than 5 years old, or the inability to attend school for children 5 to 17 years old.*

** *Chronic conditions persist for more than three months. Conditions that are considered chronic regardless of their time of onset include diabetes and heart conditions.*

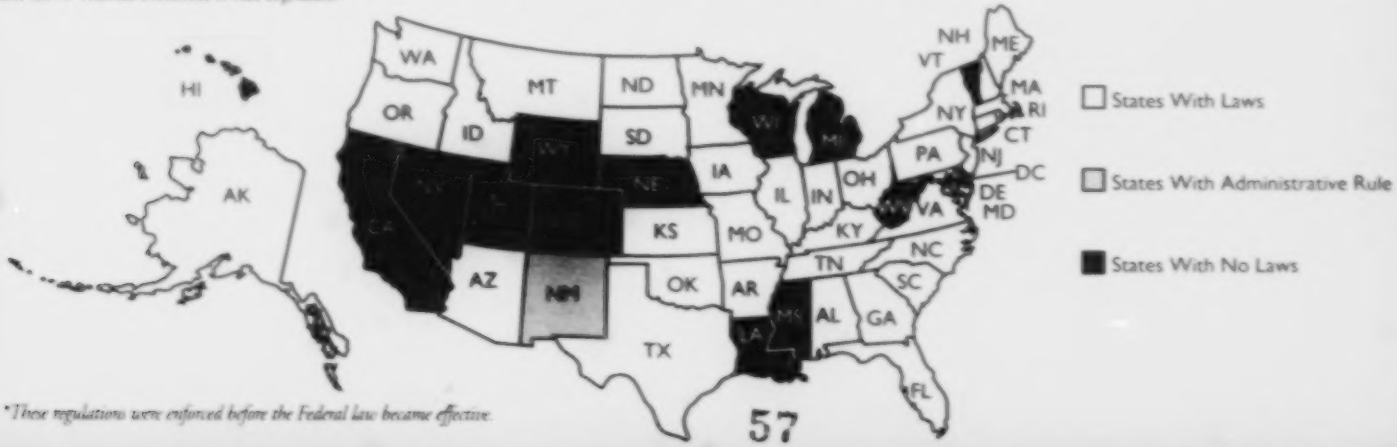
POSTPARTUM HOSPITAL DISCHARGE

In 1996, Congress passed the Newborns' and Mothers' Health Protection Act (the Act). The Act, which will become effective on January 1, 1998, requires that insurers offer a minimum hospital stay following birth. Specifically, it states that group health plans and health insurance issuers offering group health insurance coverage may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following normal vaginal delivery, or to less than 96 hours following a cesarean section.

According to the American Hospital Association's Section on Maternal and Child Health, the potential risks of postpartum stays of less than 48 hours include: 1) health problems faced by newborns, such as dehydration and jaundice, which do not appear until after the first 24 hours of life; 2) inadequate time to complete neonatal screening for metabolic and congenital disorders, including tests that cannot be performed until at least 24 hours after birth; 3) family members not alerted to infant or maternal postpartum complications, resulting in postponement of necessary treatment; 4) mothers not having adequate time to be educated about breastfeeding, family planning, immunizations, or follow-up health care; and 5) inadequate time for the development of support systems for mother and infant, particularly high-risk women based on social, demographic, or other risk factors.

STATE LAWS AND REGULATIONS REQUIRING INSURANCE COVERAGE FOR POSTPARTUM CARE: 1997*

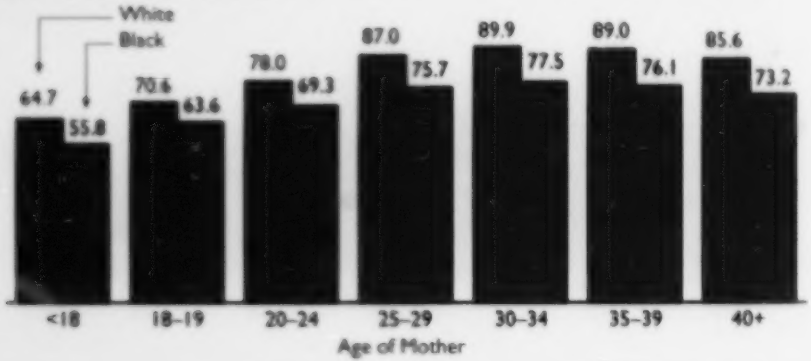
Source (III.9): National Conference of State Legislatures



*These regulations were enforced before the Federal law became effective.

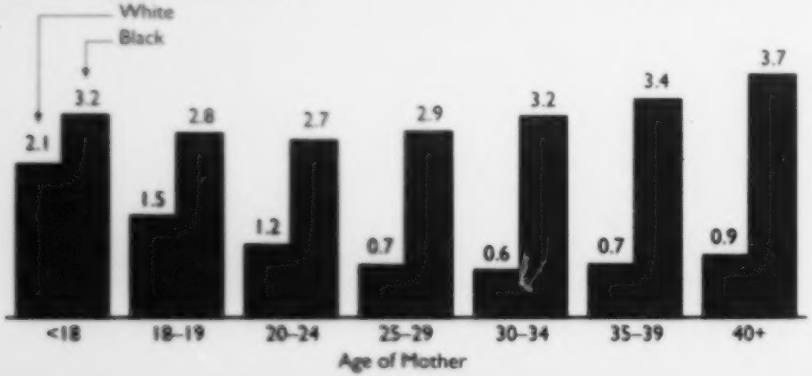
PERCENTAGE OF WOMEN WITH EARLY PRENATAL CARE, BY AGE AND RACE OF MOTHER: 1995

Source (III.10): National Center for Health Statistics



PERCENTAGE OF WOMEN WITH NO PRENATAL CARE, BY AGE AND RACE OF MOTHER: 1995

Source (III.11): National Center for Health Statistics



PRENATAL CARE

Early Prenatal Care

Overall, 81% of all mothers received prenatal care in the first trimester of pregnancy in 1995.

In 1995, 84% of white mothers, as compared to 70% of black mothers, received early prenatal care; representing a substantial racial disparity.

Women younger than 20 are less likely than older women to receive early prenatal care.

No Prenatal Care

Every year from 1983 to 1991, 6% of infants were born to mothers who initiated care during the third trimester or received no prenatal care. However, that figure is down to 4% in 1995.

Regardless of age, black women are less likely to receive prenatal care than are white women.

Risk factors for not receiving prenatal care include being less than 18 years of age, unmarried status, low educational attainment, and minority group status.

BEST COPY AVAILABLE

STATE DATA

While the indicators presented in the previous sections of this book are representative of the U.S. as a whole, the next section presents individual state health status indicators, data on infant, neonatal, and perinatal mortality, low birth weight, early prenatal care, births to women under 18, health care financing for children, and Medicaid enrollment and expenditures.

The following pages reveal stark disparities in the health status of children living in different states. In 1995, the national infant mortality rate (deaths per 1,000 live births) was 8.4. Among the 50 states, Massachusetts had the lowest rate (5.2), while the District of Columbia had the highest rate (16.2).

Women living in Alabama, Louisiana, Mississippi, South Carolina, and the District of Columbia were more likely to give birth to low birth weight babies (less than 2,500 grams or 5 lb. 8oz.) than women in other regions of the country. These same states, along with Georgia, Tennessee, North Carolina, Illinois, and South Dakota, also had the highest rates of infant mortality. High levels of poverty within these states (> 20% of children living below poverty) may be associated with the health status trends.

Poverty in the U.S. has continued to rise steadily during the last three decades. Title XIX of the Social Security Act (Medicaid) assures that children living in poverty receive adequate health care services. In 1995, the District of Columbia had the greatest proportion of children with health care financed via Medicaid (44.2%), whereas Colorado had the smallest proportion (9.9%). The national average was 21.8%. Poverty affects living conditions and access to health care and nutrition, all of which contribute to health status.

The challenge to health service providers and policy-makers continues to be eliminating the disparities among states while improving the health status of children throughout the entire Nation.

INFANT AND NEONATAL MORTALITY RATES, BY RACE OF MOTHER AND STATE, 1995, AND PERINATAL MORTALITY RATES BY RACE OF MOTHER AND STATE: 1993

Source (IV.1): National Center for Health Statistics

State	Infant Mortality[1]			Perinatal Mortality[2]			Neonatal Mortality[3]		
	All*	White	Black	All*	White	Black	All*	White	Black
UNITED STATES	**7.6**	**6.3**	**15.1**	**8.1**	**6.9**	**14.7**	**4.9**	**4.1**	**9.8**
ALABAMA	9.8	7.1	15.2	9.9	7.9	13.7	6.4	4.6	10.2
ALASKA	7.7	6.1	**	5.4	5.2	**	4.7	3.8	**
ARIZONA	7.5	7.2	17.0	7.5	6.9	16.6	4.8	4.9	8.9
ARKANSAS	8.8	7.2	14.3	10.0	9.0	13.3	5.3	4.4	8.2
CALIFORNIA	6.3	5.8	14.4	7.1	6.7	13.4	3.9	3.7	8.6
COLORADO	6.5	6.0	16.8	6.5	6.4	10.8	4.0	3.7	11.1
CONNECTICUT	7.2	6.5	12.6	7.3	6.3	14.7	5.2	4.8	9.1
DELAWARE	7.5	6.0	13.1	7.7	6.2	13.3	4.6	3.4	8.9
DIST. OF COL.	16.2	**	19.6	15.4	**	18.0	12.3	**	14.6
FLORIDA	7.5	6.0	13.0	8.5	6.8	14.7	4.7	3.7	8.2
GEORGIA	9.4	6.5	15.1	9.7	6.5	15.5	6.2	4.2	10.2
HAWAII	5.8	**	**	6.9	5.0	**	4.0	**	**
IDAHO	6.1	5.8	**	6.8	6.8	**	3.5	3.5	**
ILLINOIS	9.4	7.2	18.7	9.6	7.4	17.4	6.3	5.0	12.2
INDIANA	8.4	7.3	17.5	8.5	7.8	14.2	5.7	4.9	13.0
IOWA	8.2	7.8	21.2	7.0	6.7	19.1	5.2	5.0	**
KANSAS	7.0	6.2	17.6	6.7	7.9	17.5	4.6	4.2	10.7
KENTUCKY	7.6	7.4	10.7	6.4	8.0	11.9	4.6	4.4	6.7
LOUISIANA	9.8	6.2	15.3	10.2	7.4	14.0	6.5	4.1	10.1
MAINE	6.5	6.3	**	7.3	7.4	**	4.3	4.3	**
MARYLAND	8.9	6.0	15.3	9.8	6.9	16.2	4.0	10.8	
MASSACHUSETTS	5.2	4.7	9.0	7.0	6.6	12.6	3.7	3.3	[illegible]9
MICHIGAN	8.3	6.2	17.3	7.9	6.4	13.8	5.4	4.0	11.5
MINNESOTA	6.7	6.0	17.6	7.0	6.6	12.7	4.0	3.7	8.3
MISSISSIPPI	10.5	7.0	14.7	11.1	6.8	13.7	6.2	4.2	8.5
MISSOURI	7.4	6.4	13.8	8.2	6.9	14.6	4.6	3.9	8.7
MONTANA	7.0	7.0	**	7.5	7.8	**	3.7	3.7	**
NEBRASKA	7.4	7.3	**	8.0	7.2	18.2	5.2	5.1	**
NEVADA	5.7	5.5	**	6.4	6.1	10.9	2.8	2.9	**
NEW HAMPSHIRE	5.5	5.5	**	6.9	7.0	**	3.7	3.7	**
NEW JERSEY	6.6	5.3	13.3	6.3	6.8	14.7	4.6	3.9	8.5
NEW MEXICO	6.2	6.1	**	6.4	6.2	**	4.2	4.4	**
NEW YORK	7.7	6.2	13.9	9.3	7.7	15.8	5.4	4.6	9.3
NORTH CAROLINA	9.2	6.7	15.9	10.3	7.6	16.7	6.4	4.6	11.3
NORTH DAKOTA	7.2	6.7	**	7.2	7.1	**	4.1	4.1	**
OHIO	8.7	7.3	17.5	9.0	7.9	15.3	6.0	5.0	11.8
OKLAHOMA	8.3	8.0	15.1	8.3	7.5	16.1	4.9	4.7	8.5
OREGON	6.1	5.9	**	5.7	5.8	**	3.2	3.2	**
PENNSYLVANIA	7.8	6.2	17.6	8.4	7.3	14.5	5.3	4.4	11.6
RHODE ISLAND	7.2	7.0	**	7.6	7.5	**	5.6	5.4	**
SOUTH CAROLINA	9.6	6.7	14.6	10.7	7.4	16.3	6.6	4.5	10.4
SOUTH DAKOTA	9.5	7.9	**	7.5	6.9	**	5.2	4.6	**
TENNESSEE	9.3	6.8	17.9	6.0	6.9	14.6	5.4	3.8	11.3
TEXAS	6.5	5.9	11.7	7.1	6.3	12.7	3.8	3.5	6.5
UTAH	5.4	5.3	**	5.4	5.4	**	3.2	3.2	**
VERMONT	6.0	6.2	**	5.5	5.4	**	4.3	4.4	**
VIRGINIA	7.8	5.7	15.3	8.2	6.3	14.4	5.5	3.8	11.1
WASHINGTON	5.9	5.6	16.2	5.5	5.5	12.3	3.4	3.3	9.8
WEST VIRGINIA	7.9	7.6	**	6.7	6.5	**	5.3	4.9	**
WISCONSIN	7.3	6.3	18.6	7.3	6.6	12.7	4.6	4.1	10.6
WYOMING	7.7	6.8	**	7.1	6.9	**	3.7	3.4	**

1 Rates are deaths less than one year per 1,000 live births in specified group.

2 Rates are fetal deaths ≥ 28 weeks and infant deaths < 7 days per 1,000 live births and specified fetal deaths.

3 Rates are deaths under 28 days per 1,000 live births in specified group.

** Rates include races in addition to black and white.*

*** Fewer than 20 deaths, rates not shown.*

PERCENTAGE OF LOW BIRTH WEIGHT* INFANTS, WOMEN RECEIVING FIRST TRIMESTER PRENATAL CARE, AND BIRTHS TO WOMEN UNDER 18, BY RACE OF MOTHER AND STATE: 1995

Source (IV.2): National Center for Health Statistics

State	Percentage Low Birth Weight			Percentage With Early Prenatal Care			Percentage of Births to Women <18			
	All[1]	White	Black	All[1]	White	Black	All[1]	White	Black	Hispanic[2]
UNITED STATES	**7.3**	**6.2**	**13.1**	**81.3**	**83.6**	**70.4**	**5.3**	**4.3**	**10.8**	**7.6**
ALABAMA	9.0	7.1	13.0	81.7	87.8	69.5	7.7	5.3	12.8	4.8
ALASKA	5.3	5.1	12.4	83.4	85.7	85.3	4.1	2.7	6.1	4.2
ARIZONA	6.8	6.6	13.1	72.1	73.2	68.9	6.1	5.9	9.0	9.5
ARKANSAS	8.2	6.8	13.1	76.6	80.8	62.1	8.0	6.0	15.2	6.0
CALIFORNIA	6.1	5.5	12.0	78.5	78.5	76.3	5.0	5.0	8.1	6.9
COLORADO	8.4	8.0	15.9	80.4	81.1	72.9	4.9	4.7	8.9	10.4
CONNECTICUT	7.1	6.3	12.7	87.8	89.5	76.3	3.7	3.0	9.1	11.7
DELAWARE	8.4	7.0	12.9	85.3	88.5	74.4	5.7	3.7	12.6	9.6
DIST. OF COL.	13.4	5.6	15.9	59.8	76.9	54.5	7.3	2.6	8.9	5.4
FLORIDA	7.7	6.4	12.1	82.6	85.9	71.3	5.7	4.2	10.9	5.5
GEORGIA	8.8	6.5	13.1	84.2	88.8	75.5	7.1	4.9	11.5	6.4
HAWAII	7.0	5.3	11.1	83.7	88.8	91.9	3.5	1.3	**	7.2
IDAHO	5.9	5.8	**	79.9	80.1	78.3	4.8	4.8	**	8.3
ILLINOIS	7.9	6.1	14.5	80.8	84.4	67.1	5.3	3.6	12.6	6.8
INDIANA	7.5	6.9	13.0	80.9	82.5	66.9	5.5	4.7	12.4	7.2
IOWA	6.0	5.8	11.1	87.1	87.7	72.2	4.0	3.6	15.7	9.3
KANSAS	6.4	5.9	12.2	85.7	86.8	75.0	4.8	4.1	12.4	8.8
KENTUCKY	7.6	7.1	12.8	84.3	85.7	71.2	6.7	6.1	12.5	7.7
LOUISIANA	9.7	6.7	14.0	80.7	88.3	70.0	7.8	4.5	12.6	4.9
MAINE	6.1	6.0	**	89.1	89.4	78.2	3.7	3.7	**	**
MARYLAND	8.5	6.2	13.5	87.9	92.4	77.7	4.4	2.4	8.9	4.5
MASSACHUSETTS	6.3	5.9	10.4	89.3	90.8	78.7	2.9	2.6	6.8	10.2
MICHIGAN	7.7	6.3	14.0	83.6	86.8	69.5	4.9	3.4	11.1	8.3
MINNESOTA	5.9	5.5	12.1	83.6	86.3	62.9	3.2	2.4	12.8	7.7
MISSISSIPPI	9.8	7.0	13.0	77.2	87.0	66.1	10.0	5.8	14.8	**
MISSOURI	7.6	6.5	14.1	85.2	87.7	71.7	5.4	4.2	12.2	7.1
MONTANA	5.8	5.9	**	81.5	83.5	85.0	4.3	3.5	**	7.1
NEBRASKA	6.3	6.0	12.0	84.1	85.2	70.5	3.6	3.1	11.2	7.5
NEVADA	7.4	6.7	13.6	75.7	76.6	65.9	5.2	4.8	11.5	7.0
NEW HAMPSHIRE	5.5	5.5	**	90.0	90.1	82.9	2.3	2.3	**	**
NEW JERSEY	7.6	6.2	13.1	82.8	86.4	67.3	3.4	2.3	8.8	6.6
NEW MEXICO	7.5	7.7	10.5	69.5	71.6	60.6	7.7	7.6	11.2	10.6
NEW YORK	7.6	6.4	12.4	78.0	81.5	66.5	3.7	3.0	6.9	6.4
NORTH CAROLINA	8.7	6.8	13.8	83.5	88.3	71.3	6.2	4.2	11.6	6.1
NORTH DAKOTA	5.3	5.1	**	83.9	85.2	76.8	3.2	2.5	**	**
OHIO	7.6	6.5	13.9	84.7	87.3	69.5	5.3	4.1	12.2	9.5
OKLAHOMA	7.0	6.4	12.5	78.2	80.9	66.1	6.5	5.6	11.9	8.8
OREGON	5.5	5.4	10.3	78.8	79.2	72.8	4.9	4.7	13.9	8.4
PENNSYLVANIA	7.4	6.2	14.2	83.4	86.5	65.3	4.3	3.1	11.6	12.4
RHODE ISLAND	6.8	6.3	11.3	89.7	91.1	77.4	3.9	3.3	8.4	7.8
SOUTH CAROLINA	9.3	6.8	13.7	78.5	85.5	66.2	7.2	4.8	11.6	7.6
SOUTH DAKOTA	5.6	5.5	**	81.9	85.6	72.7	3.7	2.7	**	**
TENNESSEE	8.7	7.2	14.0	82.8	86.2	71.1	6.6	5.0	12.5	6.1
TEXAS	7.1	6.4	12.2	77.3	77.6	73.7	6.9	6.6	10.9	9.0
UTAH	6.3	6.2	10.7	84.3	85.3	66.4	3.9	3.8	9.5	9.1
VERMONT	5.4	5.4	**	87.3	87.5	70.3	2.0	2.0	**	**
VIRGINIA	7.7	6.1	12.9	83.8	87.8	71.7	4.4	3.0	9.5	4.7
WASHINGTON	5.5	5.2	11.1	82.7	83.6	75.8	4.3	4.0	8.6	8.1
WEST VIRGINIA	7.9	7.6	16.5	82.0	82.6	66.8	6.1	5.9	11.0	**
WISCONSIN	6.0	5.1	13.7	83.4	86.6	65.5	4.0	2.7	14.4	9.4
WYOMING	7.4	7.3	**	83.1	83.9	72.7	5.1	4.8	**	9.7

** Less than 2,500 grams (5 lb. 8 oz.).*

*** Fewer than 20 occurrences.*

[1]Rates include races in addition to black and white.

[2]Hispanic can be of any race.

MEDICAID RECIPIENTS AND EXPENDITURES AND PERCENTAGE OF MEDICAID RECIPIENTS WITH AN EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICE, UNDER AGE 21: 1995

Source (IV.3): American Academy of Pediatrics

State	Medicaid Recipients	Medicaid Expenditures per Recipient Ages 1—5	Medicaid Expenditures for Recipient Ages 6—20	% Medicaid Recipients who Used EPSDT Services
UNITED STATES	**18,995,694**	**$1,038**	**$1,501**	**34**
ALABAMA	297,696	$922	$1,212	45
ALASKA	41,102	$1,176	$2,737	11
ARIZONA	326,824	$188	$230	72
ARKANSAS	184,313	$1,763	$2,604	44
CALIFORNIA	2,553,737	$727	$956	36
COLORADO	159,404	$1,002	$1,984	33
CONNECTICUT	188,935	$865	$1,607	33
DELAWARE	49,983	$1,943	$2,321	42
DIST. OF COL.	75,598	$1,242	$1,649	2
FLORIDA	976,239	$942	$1,261	21
GEORGIA	672,467	$1,358	$1,392	46
HAWAII	12,508	$912	$894	9
IDAHO	70,882	$920	$1,648	26
ILLINOIS	872,702	$1,169	$1,519	56
INDIANA	310,593	$865	$1,157	NA
IOWA	157,355	$1,077	$2,102	22
KANSAS	146,076	$879	$1,703	NA
KENTUCKY	316,710	$1,247	$1,576	11
LOUISIANA	458,180	$1,100	$1,914	61
MAINE	74,761	$1,671	$2,462	61
MARYLAND	217,867	$1,453	$2,671	41
MASSACHUSETTS	345,039	$1,289	$1,659	27
MICHIGAN	624,539	$963	$1,075	28
MINNESOTA	256,759	$1,425	$2,031	16
MISSISSIPPI	281,815	$975	$1,355	60
MISSOURI	389,926	$1,073	$1,165	38
MONTANA	54,018	$959	$1,855	27
NEBRASKA	102,145	$951	$1,532	37
NEVADA	59,836	$1,333	$2,339	47
NEW HAMPSHIRE	52,716	$1,141	$1,693	34
NEW JERSEY	400,320	$1,393	$1,690	15
NEW MEXICO	178,477	$998	$1,614	21
NEW YORK	1,612,604	$1,791	$2,628	37
NORTH CAROLINA	593,389	$946	$1,352	57
NORTH DAKOTA	30,356	$1,073	$1,897	NA
OHIO	834,425	$1,055	$1,324	NA
OKLAHOMA	218,860	$884	$1,724	23
OREGON	170,328	$1,478	$1,959	88
PENNSYLVANIA	620,011	$1,091	$1,617	34
RHODE ISLAND	67,386	$1,146	$1,502	36
SOUTH CAROLINA	272,508	$779	$1,724	38
SOUTH DAKOTA	43,734	$976	$1,862	48
TENNESSEE	638,148	$662	$1,472	NA
TEXAS	1,620,043	$874	$1,247	45
UTAH	98,476	$1,097	$1,600	NA
VERMONT	53,309	$899	$1,507	61
VIRGINIA	404,491	$836	$1,078	30
WASHINGTON	339,227	$568	$905	2
WEST VIRGINIA	218,413	$979	$1,813	34
WISCONSIN	219,603	$962	$1,518	22
WYOMING	30,634	$1,125	$1,538	30

Note: NA=Not Available

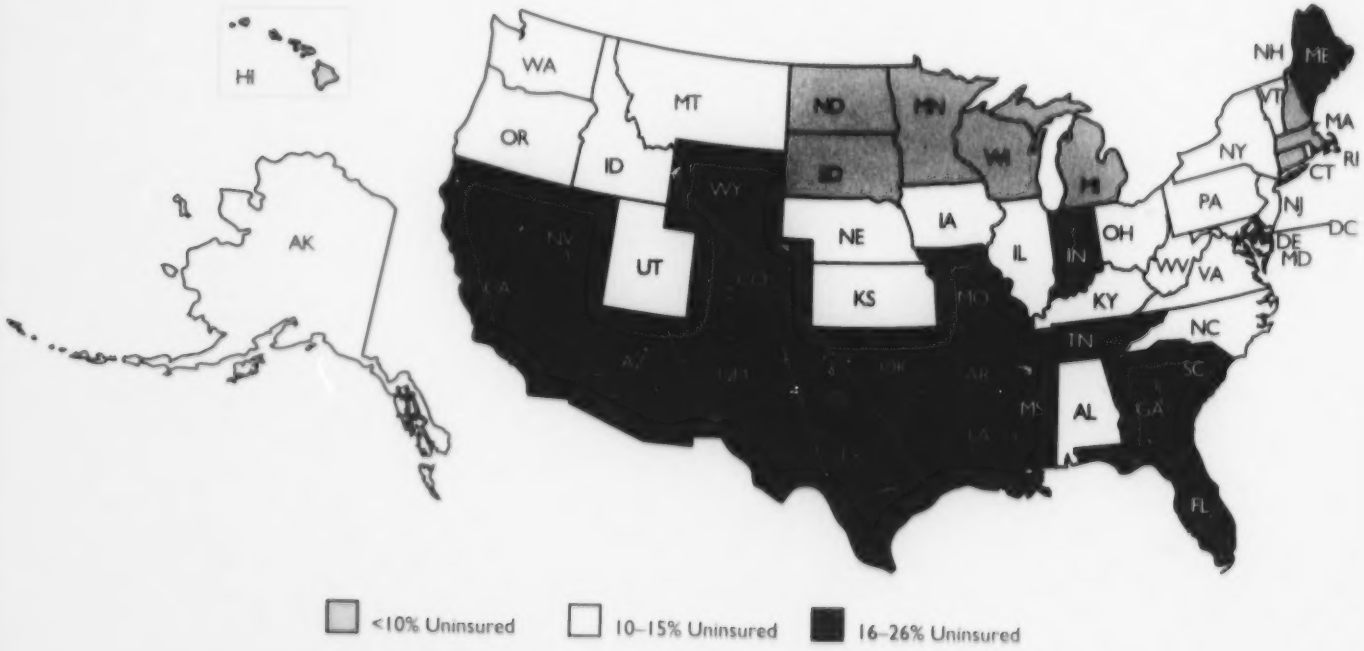
HEALTH INSURANCE STATUS FOR CHILDREN UNDER AGE 22: 1995

Source (IV.4): American Academy of Pediatrics

State	Percent with Private/Employer-Based Insurance	Percent Enrolled in Medicaid	Percent Uninsured*
UNITED STATES	**62.7**	**21.8**	**15.5**
ALABAMA	63.2	21.7	15.0
ALASKA	60.2	29.2	10.5
ARIZONA	55.3	21.6	23.2
ARKANSAS	59.7	21.2	19.0
CALIFORNIA	52.9	28.1	19.0
COLORADO	73.4	9.9	16.6
CONNECTICUT	73.4	17.6	9.0
DELAWARE	64.0	19.7	16.3
DIST. OF COL.	36.4	44.2	19.4
FLORIDA	58.8	21.7	19.5
GEORGIA	62.7	20.2	17.1
HAWAII	68.3	23.4	8.2
IDAHO	65.8	20.4	13.8
ILLINOIS	64.7	24.9	10.5
INDIANA	68.9	15.1	16.1
IOWA	72.6	13.7	13.8
KANSAS	73.0	14.3	12.7
KENTUCKY	65.8	20.1	14.1
LOUISIANA	48.8	30.8	20.4
MAINE	69.1	11.9	19.0
MARYLAND	69.9	15.2	14.9
MASSACHUSETTS	72.1	18.7	9.2
MICHIGAN	70.4	19.7	9.9
MINNESOTA	73.9	20.3	5.8
MISSISSIPPI	47.5	30.0	22.5
MISSOURI	68.5	15.5	16.0
MONTANA	60.1	27.3	12.6
NEBRASKA	76.2	13.7	10.1
NEVADA	64.6	11.9	23.5
NEW HAMPSHIRE	76.4	14.6	9.0
NEW JERSEY	74.6	12.5	12.9
NEW MEXICO	39.7	34.2	26.0
NEW YORK	60.0	26.3	13.7
NORTH CAROLINA	62.2	24.2	13.6
NORTH DAKOTA	77.7	14.2	8.1
OHIO	70.5	18.6	10.8
OKLAHOMA	56.4	20.3	23.2
OREGON	61.3	24.9	13.8
PENNSYLVANIA	69.0	20.0	11.0
RHODE ISLAND	72.2	13.8	14.0
SOUTH CAROLINA	55.4	27.8	16.9
SOUTH DAKOTA	68.5	22.0	9.5
TENNESSEE	56.7	26.4	16.9
TEXAS	53.0	21.4	25.6
UTAH	77.1	11.8	11.2
VERMONT	59.1	29.8	11.1
VIRGINIA	71.7	15.7	12.6
WASHINGTON	64.7	22.3	13.0
WEST VIRGINIA	55.6	31.0	13.4
WISCONSIN	71.6	21.0	7.3
WYOMING	66.7	15.6	17.6

*See map on facing page.

PERCENTAGE OF UNINSURED CHILDREN UNDER THE AGE OF 22: 1995
Source (IV.5): American Academy of Pediatrics



BEST COPY AVAILABLE

BEST COPY AVAILABLE

CITY DATA

How does the health of infants and children
America's cities compare to that of childr
nationwide? This section includes data on infa
mortality, low birth weight, and prenatal care
women and children who reside in the Natio
central cities with populations over 100,000.

As the following data indicate, the health s
tus of children living in large U.S. cities is ge
erally inferior to that of children in the Nati
as a whole. While the infant mortality rate h
decreased in both cities and the Nation, a d
parity in rates remains. Higher rates of lo
birth weight contributed to the 1995 c
infant mortality rate of 8.9 deaths per 1,0
live births; the national rate was 7.6. While t
percentage of pregnant women receiving fi
trimester prenatal care is higher in cit
(79.4%) as compared to the Nation (72.9%
the percentage of women receiving no prena
care is nearly twice as high in cities versus t
Nation as a whole (6.3% versus 3.6%).

The challenge for health service providers a
special initiatives is to eliminate these disparit
by improving the health status of children in t
Nation's cities.

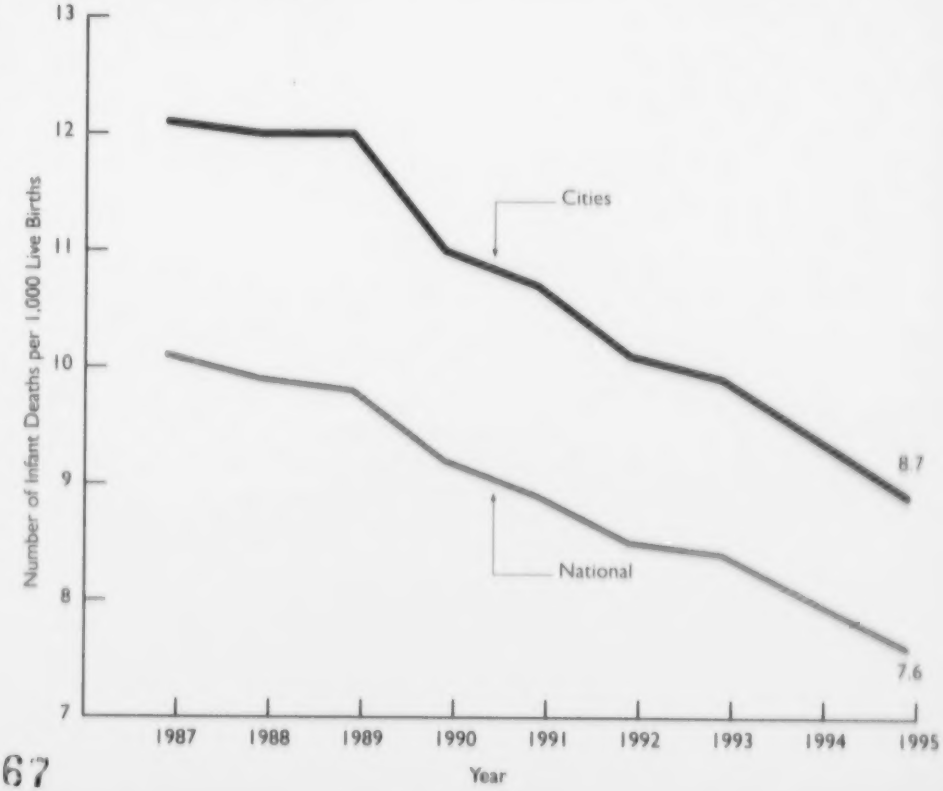
INFANT MORTALITY

In 1995, 11,538 infants born to residents of U.S. cities with populations over 100,000 died in the first year of life. The city infant mortality rate was 8.7 deaths per 1,000 live births, nearly 14% higher than the rate of 7.6 for the Nation as a whole. The 1995 rate of 8.7 represents a 7.5% decrease in the 1994 city infant mortality rate of 9.4.

Although the infant mortality rate in cities has routinely been higher than the rate in the Nation as a whole, it has steadily declined over the past decade. Between 1987 and 1995, infant mortality in cities declined more than 28%; the decline nationwide in the same period was approximately 25%.

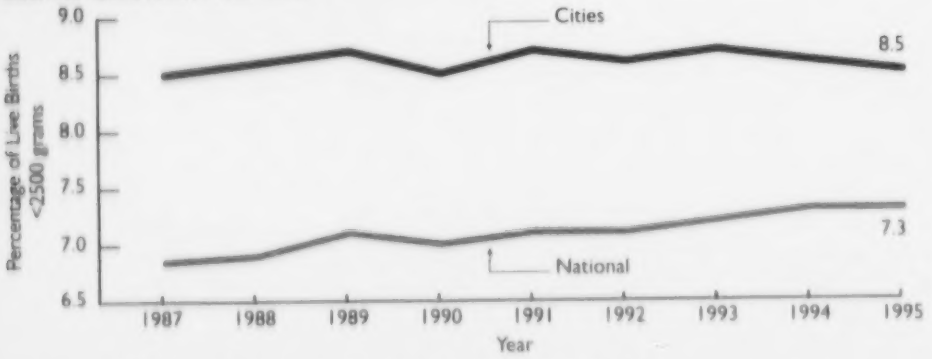
INFANT MORTALITY RATES IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1987—1995

Source (V.1): National Center for Health Statistics



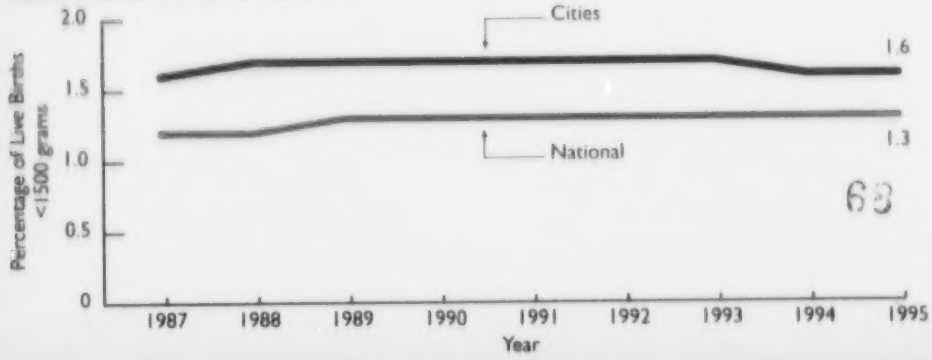
PERCENTAGE OF LOW BIRTH WEIGHT INFANTS IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1987—1995

Source (V.2): National Center for Health Statistics



PERCENTAGE OF VERY LOW BIRTH WEIGHT INFANTS IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1987—1995

Source (V.3): National Center for Health Statistics



63

BIRTH WEIGHT

Low Birth Weight

Disorders related to short gestation and lo birth weight are the number two cause neonatal mortality.* In 1995, 112,598 babi (8.5% of all live births) born to residents of U. cities with populations over 100,000 were low birth weight (weighing less than 2,5 grams or 5.5 pounds). The 1995 percentage city infants with low birth weight was 16 higher than the national percentage of 7.3%.

Very Low Birth Weight

Infants with very low birth weight (less th 1,500 grams or 3 pounds, 5 ounces) are at hig est risk for poor health outcomes. In both 19 and 1995, 1.6% of live births in cities with po ulations over 100,000 were of very low bir weight. However, it exceeded the national p centage by nearly 19%. The national percen age of very low birth weight infants h remained constant since 1989.

*Congenital anomalies are the leading cause of neonatal mortality.

PRENATAL CARE

Early Prenatal Care

Women living in U.S. cities with a population of over 100,000 are less likely to begin prenatal care in the first three months of pregnancy than women nationwide. Since 1987, the percentage of pregnant women receiving early prenatal care in cities has averaged 6.5% less per year than the national percentage.

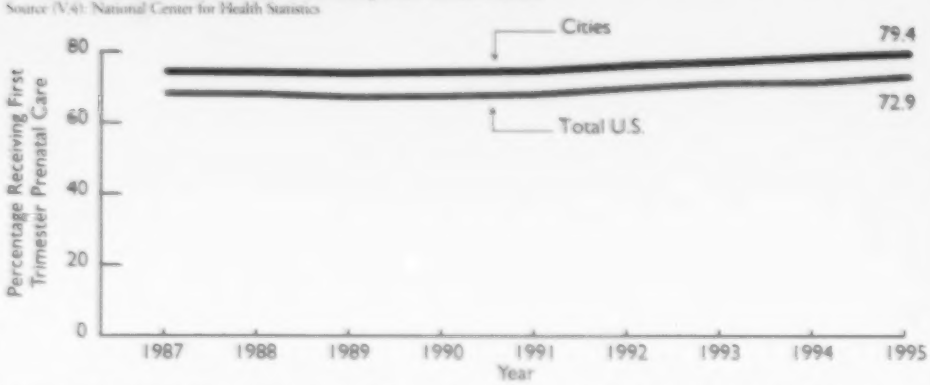
In 1995, 72.9% of pregnant women living in U.S. cities began prenatal care in the first trimester of pregnancy, compared to 79.4% nationwide. The percentage of women receiving prenatal care has increased steadily since 1989 at both the city and national levels. The corollary Healthy People 2000 Objective is to have 90% of pregnant women begin prenatal care in the first trimester.

No Prenatal Care

The percentage of pregnant women living in U.S. cities with a population of over 100,000 who received no prenatal care in the first trimester decreased slightly from 6.6% to 6.3% between 1994 and 1995. However, the percentage of women receiving no prenatal care is 75% higher among women living in cities than among the overall U.S. population.

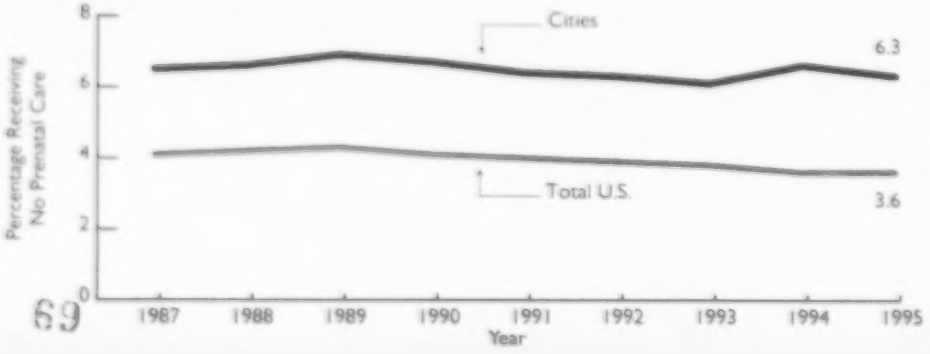
PERCENTAGE OF PREGNANT WOMEN RECEIVING FIRST TRIMESTER PRENATAL CARE IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1987–1995

Source (V.S): National Center for Health Statistics



PERCENTAGE OF PREGNANT WOMEN RECEIVING NO PRENATAL CARE IN U.S. CITIES WITH POPULATIONS OVER 100,000: 1987–1995

Source (V.S): National Center for Health Statistics



PROGRESS TOWARDS HEALTHY PEOPLE 2000 OBJECTIVES FOR THE NATION

Source (V.1): Public Health Service

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE		1995 (OR MOST CURRENT) STATISTIC
Adolescent Overweight Prevalence	Percentage of adolescents ages 12 to 17 who are overweight **(page 44)**	1.2	Overweight prevalence of no more than 15% among adolescents ages 12 to 19.	(1994) 12% of adolescents ages 12 to 17 overweight
Adolescent Physical Activity	Percentage of high school students who participated in moderate physical activity (30 minutes/day ≥5 of the 7 previous days) **(page 44)**	1.3	At least 30% of people ages 6 and older engage regularly or daily in light to moderate physical activity for at least 30 minutes/day	9th grade: (F) 27.0%; (M) 24.8% 10th grade: (F) 22.9%; (M) 23.7% 11th grade: (F) 19.6%; (M) 21.0% 12th grade: (F) 13.7%; (M) 17.2%
Adolescent Smoking	Long-term trends in 30-day prevalence of cigarette smoking for 8th–12th graders **(page 43)**	3.5	No more than 15% of adolescents become regular smokers by the age of 20	(1996) 8th Grade 21.0% 10th Grade 30.4% 12th Grade 34.0%
Adolescent Substance Abuse	Long-term trends in 30-day prevalence of use of alcohol, marijuana, and cocaine by adolescents ages 12 to 17 **(page 42)**	4.6	Used in past month by adolescents (ages 12–17)(1996) Alcohol: 12.6% Marijuana: 3.2% Cocaine: 0.6%	Alcohol: 18.8% Marijuana: 7.1% Cocaine: 0.6%

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1995 (OR MOST CURRENT) STATISTIC
Adolescent Childbearing	Live births per 1,000 adolescents (ages 10–19) **(page 38)**	5.1 No more than 50 births per 1,000 girls (17 and younger)	37.3 live births per 1,000 adolescents (ages 10-17)
Adolescent Sexual Activity	Percentage of students in grades 9–12 who have ever had sexual intercourse **(page 37)**	5.4 No more than 15% by age 15 No more than 40% by age 17	9th grade 32.1%(F); 40.6%(M) 10th 46.0% (F); 50.0% (M) 11th 60.2% (F); 57.1% (M) 12th 66.0%(F);67.1%(M)
Adolescent Firearm Mortality	Deaths by firearms per 100,000 adolescents (ages 15-19) **(page 35)**	Per 100,000 adolescents (ages 15–19): 6.1 No more than 8.2 suicides 7.3 No more than 12.9 weapon-related deaths	Per 100,000 adolescents (ages 15–19): homicide 15.6 suicide 7.0 unintentional 1.5
Hospitalization	Number of hospital discharges among children, by illness **(page 26)**	6.3 Less than 10% prevalence of Mental disorders among children and adolescents 11.1b No more than 225 per 100,000 children aged 14 and younger hospitalized for asthma	(1994) 4.5 discharges per 100 children 284,000 discharges due to mental disorder (ages 10-21) Hospitalizations: 485,000 for respiratory disease (ages 1-19)

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1995 (OR MOST CURRENT) STATISTIC
Child Abuse	Cases per 100,000 children under 18 **(page 31)**	Per 1,000 children under age 18 by type of abuse: 7.4a physical, less than 5.7 7.4b sexual, less than 2.5 7.4c emotional, less than 3.4 7.4d neglect, less than 15.9	15 per 1,000 children abused (percentage of total number): physical 24.5% sexual 12.6% emotional 4.5% neglect 52.3%
School Dropout Rates	Percentage of adolescents (ages 16-24) not enrolled/completed high school **(page 14)**	8.2 At least 90% high school graduation rate	Adolescents not in school: Hispanic 30.0% white 12.1% black 8.6%
Child Injury Mortality	Injury-related deaths per 100,000 children in specified age group **(pages 24-25)**	7.1a No more than 3.1 homicides among children under 3 9.3a No more than 5.5 motor vehicle deaths per 100,000 children under 14 9.5a No more than 2.2 deaths due to drowning, fires, and burns: deaths per 100,000 children under 4 9.6 No more than 3.3 fire-related deaths per 100,000 children under 4	Deaths per 100,000 population: ages 1-4 5-14 Homicide: 2.9 1.5 Motor vehicle crashes: 5.2 5.4 Drowning: 3.4 1.1 2.8 0.8

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1995 (OR MOST CURRENT) STATISTIC
Adolescent Mortality	Leading causes of deaths per 100,000 adolescents (ages 15-19) **(page 34)**	(Age-related objective:) No more than 85 deaths per 100,000 adolescents (ages 15-24) 9.3b No more than 33 deaths by motor vehicle crashes per 100,000 adolescents (ages 15-24)	Deaths per 100,000 adolescents (ages 15–19): Unintentional Injury: 36.7 Motor vehicle crashes: 28.6
Lead Exposure	Percentage of children ages 1 to 5 with elevated blood lead levels (≥ 10 ug/dL) **(page 29)**	11.4 No more than 500,00 children (ages 6 mos. to 5 yrs.) and 0 infants with elevated blood levels	(1994) Ages 1 to 5 2.3% white 11.2% black 4.0% Mexican American
Dental Caries	Percentages of children (ages 5-17) with dental caries by race/ethnicity **(page 32)**	13.1 Proportion of children with one or more caries: no more than 35% (ages 6-8) no more than 60% (aged 15)	(1991)—(ages 5–17) 44.3% white 39.4% black 48.6% Mexican American
Infant Mortality	Infant deaths per 1,000 live births **(pages 19, 59, & 65)**	No more than 7 deaths per 1,000 live births	7.6 deaths per 1,000 live births (versus 55.7 in 1935)
Postneonatal Mortality	Deaths per 100,000 live births among infants ages 28 days to 11 months **(page 20)**	14.1g No more than 2.5 postneonatal deaths per 1,000 live births	267.4 deaths per 100,000 live births (2.7 deaths per 1,000 live births)

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1995 (OR MOST CURRENT) STATISTIC
Neonatal Mortality	Deaths of infants less than 28 days old per 100,000 live births **(pages 20 & 59)**	14.1 No more than 4.5 deaths per 1,000 live births	491.2 deaths per 100,000 live births (4.9 deaths per 1,000 live births)
Maternal Mortality	Maternal deaths per 100,000 live births **(page 21)**	14.3 No more than 3.3 deaths per 100,000 live births	7.1 deaths per 100,000 live births (versus 582 in 1935)
Low Birth Weight	Percentage of live births less than 2,500 grams (5.5 lbs.) **(pages 17, 60, & 66)**	14.5 No more than 5% of live births	7.3% of live births
Infant Feeding	Breast feeding in-hospital and 5–6 months postpartum **(page 22)**	14.9 75% in-hospital; 50% at 5-6 months postpartum	(1996) 59.2% in-hospital 5-6 months postpartum: Hispanic 21.1% white 26.0% black 12.1%
Prenatal Care	Initiation of prenatal care in the first trimester **(page 56)**	14.11 90% of all pregnant women	81% mothers received care in the first trimester
Adolescent Condom Use	Percentage of sexually active high school students using a condom during last sexual intercourse **(page 37)**	18.4 Condom used during last intercourse): Young women (15-19): 60% Young men (15-19): 75%	9th grade 62.9% 10th 59.7% 11th 52.3% 12th 49.5%

CHILD HEALTH USA INDICATOR	CHILD HEALTH USA MEASURE	HP2000 OBJECTIVE	1995 (OR MOST CURRENT) STATISTIC
Vaccination	Coverage levels among children (ages 19–35 months) **(page 48)**	20.11 At least 90% of basic immunization series among children under age 2	Children (19-35 mos.) receiving vaccinations: DTP 95% Polio 88% Hib 92% MCV 90% Hep B 68%
Physician Visits	Percentage of children with no physician visits in past year **(page 50)**	Population receiving basic preventive services: 21.2a up to 24 months 90% 21.2b ages 2-12 80% 21.2c ages 13-18 50%	Children < 20 years of age: 79.3% seen by a physician in the past year
Health Insurance Coverage	Percentage of children under 18 with no insurance coverage **(pages 47, 62 & 63)**	21.3 95% of population have source of ongoing primary care 21.4 No citizen has financial barrier to receiving preventive services	(1996) 13.8% children with no coverage 21.8% children in poverty with no coverage
Child Mortality	Deaths due to leading causes per 100,000 children in specified age group **(page 24)**	(Age-related objective): No more than 28 deaths per 100,000 children (ages 1-14)	Deaths per 100,000 children: ages 1-4 27.8 ages 5-14 16.9

REFERENCES

I. POPULATION CHARACTERISTICS

(I.1) U.S. Bureau of the Census. (1996). *U.S. Population Estimates by Age, Sex, Race, and Hispanic Origin, 1990-1996.* (Population Paper Listing No. 57).

(I.2) U.S. Bureau of the Census. (March 1996). *Current Population Survey.*

(I.3) U.S. Bureau of the Census. (March 1996). *Current Population Survey.*

(I.4) U.S. Bureau of Labor Statistics. (March 1996). *Current Population Survey.* Unpublished data.

(I.5) U.S. Bureau of the Census. (1993). Who's Minding the Preschoolers? *Current Population Reports, Household Economics Studies* (Series P-70).

(I.6) U.S. Department of Education. (1996). *Digest of Education Statistics.* National Center for Education Statistics.

U.S. Department of Education. (1993). *Dropout Rates in the United States.* National Center for Education Statistics.

II. HEALTH STATUS

(II.1) Ventura, S.J., Martin, J.A., Curtin, S.C., Mathews, T.J. (1997). Report of Final Natality Statistics, 1995. *Monthly Vital Statistics Report.* 45(11), Suppl. 2. Hyattsville, Md.: National Center for Health Statistics.

(II.2) National Center for Health Statistics. (1996-97). *Health, United States.* Hyattsville, Md.: DHHS.

(II.3) Anderson, R. and Murphy, S.L. (1997). *Advance Report of Final Mortality Statistics.* 46; (Suppl.). Hyattsville, Md.: National Center for Health Statistics.

(II.4) Anderson, R. and Murphy, S.L. (1997). *Advance Report of Final Mortality Statistics.* 46; (Suppl.). Hyattsville, Md.: National Center for Health Statistics.

(II.5) Anderson, R. and Murphy, S.L. (1997). *Advance Report of Final Mortality Statistics.* 46; (Suppl.). Hyattsville, Md.: National Center for Health Statistics.

(II.6) National Center for Health Statistics. (June 12, 1997). *Monthly Vital Statistics Report.* 45(11) 52. Hyattsville, Md.: Public Health Service.

Hoyert, D.L. (1994). Effect on Mortality Rates of the 1989 Change in Tabulating Race. *Vital Health Statistics,* 20(25). Hyattsville, Md.: National Center for Health Statistics.

(II.7) Ross Products Division, Abbott Laboratories. (1996). *Ross Mothers' Survey.*

(II.8) Ross Products Division, Abbott Laboratories. (1996). *Ross Mothers' Survey.*

(II.9) Anderson, R. and Murphy, S.L. (1997). *Advance Report of Final Mortality Statistics.* 46; (Suppl.). Hyattsville, Md.: National Center for Health Statistics.

(II.10) Anderson, R. and Murphy, S.L. (1997). *Advance Report of Final Mortality Statistics.* 46; (Suppl.). Hyattsville, Md.: National Center for Health Statistics. Also unpublished data.

(II.11) National Center for Health Statistics. (1994). *National Hospital Discharge Survey.* Unpublished data.

(II.12) National Center for Health Statistics. (1994). *National Hospital Discharge Survey.* Unpublished data.

(II.13) Centers for Disease Control and Prevention. (February 21, 1997). *Morbidity and Mortality Weekly Report,* 46(7). Atlanta, Ga.: DHHS.

Brody, D.L. et al (1994). Blood Lead Levels in the U.S. Population: Phase I of the Third National Health and Nutrition Examination Survey (NHANES III, 1988-1991). *Journal of the American Medical Association.* 272(4): 277-283.

(II.14) Centers for Disease Control and Prevention. (February 21, 1997). *Morbidity and Mortality Weekly Report,* 46(7). Atlanta, Ga.: DHHS.

(II.15) Centers for Disease Control and Prevention, National Center for HIV, STD, TB Prevention. (1996). *HIV/AIDS Surveillance Report, Year-end Edition.* Atlanta, Ga: Public Health Service.

Centers for Disease Control and Prevention. (November 22, 1996). *Morbidity and Mortality Weekly Report.* 45(46). Atlanta, Ga.: DHHS.

(II.16) National Center on Child Abuse and Neglect. (1997). Child Maltreatment 1995: *Reports from the States to the National Child Abuse and Neglect Data System.* Washington, D.C.: U.S. Government Printing Office.

(II.17) National Center on Child Abuse and Neglect. (1997). Child Maltreatment 1995: *Reports from the States to the National Child Abuse and Neglect Data System.* Washington, D.C.: U.S. Government Printing Office.

(II.18) Kaste, L.M. et al. (1996). Coronal Caries in the Primary and Permanent Dentition of Children and Adolescents 1-17 Years of Age: United States, 1988-1991. *Journal of Dental Residency.* 75: 631-641. Rockville, Md.: National Institutes of Health. National Institute of Dental Research, Division of Epidemiology and Oral Disease Prevention.

(II.19) Siegal, M.D., Farquhar, C.L., and Bouchard, J.M. (1997). Dental Sealants. *Public Health Reports,* 112: 99-106.

Centers for Disease Control and Prevention. (1997). *CDC's Oral Health Program at a Glance: 1996-1997.* Http://www.cdc.gov/nccdphp/oh/ataglanc.htm.

(II.20) Anderson, R. and Murphy, S.L. (1997). *Advance Report of Final Mortality Statistics.* 46(Suppl.). Hyattsville, Md.: National Center for Health Statistics. Also unpublished data.

(II.21) Anderson, R. and Murphy, S.L. (1997). *Advance Report of Final Mortality Statistics.* 46(Suppl.). Hyattsville, Md.: National Center for Health Statistics. Also unpublished data.

(II.22) Henshaw, S. (1997). U.S. Teenage Pregnancy Statistics. New York: The Alan Guttmacher Institute. Unpublished data.

Ventura, S.J., Martin, J.A., Mathews, T.J., and Clarke, S.C. (1994). Advance Report of Final Natality Statistics. *Monthly Vital Statistics Report.* 44(11); (Suppl.). Hyattsville, Md.: National Center for Health Statistics.

(II.23) Centers for Disease Control and Prevention. (September 7, 1996). CDC Surveillance Summaries: Youth Risk Behavior Surveillance—United States, 1995. *Morbidity and Morality Weekly Report.* 45(No. SS(4). Atlanta, Ga.: DHHS.

(II.24) Centers for Disease Control and Prevention. (September 7, 1996). CDC Surveillance Summaries: Youth Risk Behavior Surveillance—United States, 1995. *Morbidity and Morality Weekly Report.* 45(No. SS(4). Atlanta, Ga.: DHHS.

(II.25) Ventura, S.J., Martin, J.A., Curtin, S.C., and Mathews, T.J. (1997). Report of Final Natality Statistics. *Monthly Vital Statistics Report.* 45(11); (Suppl. 2). Hyattsville, Md.: National Center for Health Statistics.

(II.26) Centers for Disease Control and Prevention, National Center for HIV, STD, TB Prevention. (1996). *HIV/AIDS Surveillance Report, Year-end Edition.* Atlanta, Ga: Public Health Service.

(II.27) Centers for Disease Control and Prevention, National Center for HIV, STD, TB Prevention. (1996). *HIV/AIDS Surveillance Report, Year-end Edition.* Atlanta, Ga: Public Health Service.

(II.28) Centers for Disease Control and Prevention, National Center for HIV, STD, TB Prevention. (1996). *HIV/AIDS Surveillance Report, Year-end Edition.* Atlanta, Ga: Public Health Service.

(II.29) Gfroerer, J. et al. (1997). *Preliminary Results from the 1996 National Household Survey on Drug Abuse.* Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Rockville, Md.: DHHS.

(II.30) Gfroerer, J. et al. (1997). *Preliminary Results from the 1996 National Household Survey on Drug Abuse.* Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Rockville, Md.: DHHS.

(II.31) The University of Michigan Institute for Social Research. (1996). *The Monitoring the Future Study, 1975-1996.* (National Institute on Drug Abuse, National Institutes of Health). Rockville, Md.: Public Health Service.

(II.32) Centers for Disease Control and Prevention. (September 7, 1996). CDC Surveillance Summaries: Youth Risk Behavior Surveillance—United States, 1995. *Morbidity and Morality Weekly Report.* 45(No. SS 4). Atlanta, Ga.: DHHS.

Heath, G., Pratt, M., Warren, C., and Kann, L. (1994). Physical Activity Patterns in American High School Students. *Archives of Pediatrics & Adolescent Medicine.* 148: 1131-1136.

Troiano, R.P. et al. (1995). Overweight Prevalence and Trends for Adolescents. *Archives of Pediatrics & Adolescent Medicine.* 149: 1085-1091.

Centers for Disease Control and Prevention. (Fall 1996). *Chronic Disease Notes and Reports.* 9(2). Atlanta, Ga.: Public Health Service.

(II.33) Centers for Disease Control and Prevention. (September 7, 1996). CDC Surveillance Summaries: Youth Risk Behavior Surveillance—United States, 1995. *Morbidity and Morality Weekly Report.* 45(No. SS 4). Atlanta, Ga.: DHHS.

III. HEALTH SERVICES AND UTILIZATION

(III.1) Fronstin, P. (1996). Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1996 Current Population Survey. *Appendix to Employee Benefit Research Institute Issue Brief No. 179, November 1996.* Washington, D.C.: Employee Benefit Research Institute.

Fronstin, P. and Pierron, B. (1997). Expanding Health Insurance for Children: Examining the Alternatives. *Employee Benefit Issue Brief No. 187, July 1997.* Washington, D.C.: Employee Benefit Research Institute.

National Maternal and Child Health Policy Consortium. (July 1997). *Facts About Uninsured Children.* Unpublished.

(III.2) Centers for Disease Control and Prevention. (February 28, 1997). National, State, and Urban Area Vaccination Coverage Levels Among Children Aged 19–35 Months—United States, January–December 1995. *Morbidity and Mortality Weekly Report.* 46(8). Atlanta, Ga.: Public Health Service.

Centers for Disease Control and Prevention. (January 24, 1997). Poliomyelitis Prevention in the U.S.: Introduction of a Sequential Vaccination Schedule of Inactivated Poliovirus Vaccine Followed by Oral Poliovirus Vaccine. *Morbidity and Mortality Weekly Report.* 46(RR-3). Atlanta, Ga.: Public Health Service.

(III.3) Centers for Disease Control and Prevention. (February 28, 1997). National, State, and Urban Area Vaccination Coverage Levels Among Children Aged 19–35 Months—United States, January–December 1995. *Morbidity and Mortality Weekly Report.* 46(8). Atlanta, Ga.: Public Health Service.

(III.4) National Center for Health Statistics. (1994). *National Health Interview Survey, 1993.* Public Health Service. Unpublished data.

(III.5) National Center for Health Statistics. (1994). *National Health Interview Survey, 1993.* Public Health Service. Unpublished data.

(III.6) National Center for Health Statistics. (1994). *National Health Interview Survey, 1993.* Public Health Service. Unpublished data.

(III.7) National Center for Health Statistics. (1994). *National Health Interview Survey, 1993.* Public Health Service. Unpublished data.

(III.8) National Center for Health Statistics. (1994). *National Health Interview Survey, 1993.* Public Health Service. Unpublished data.

(III.9) Perez, K.E. (1997) National Conference of State Legislatures. Unpublished Data.

(III.10) Ventura, S.J., Martin, J.A., Curtin, S.C., Mathews, T.J. (1997). Report of Final Natality Statistics, 1995. *Monthly Vital Statistics Report. 45(11):* (Suppl. 2). Hyattsville, Md.: National Center for Health Statistics.

(III.11) Ventura, S.J., Martin, J.A., Curt
S.C., Mathews, T.J. (1997). Repor
Final Natality Statistics, 19
Monthly Vital Statistics Report. 45(1
(Suppl. 2). Hyattsville, Md.: Natio
Center for Health Statistics.

IV. STATE-SPECIFIC DATA

(IV.1) Ventura, S.J., Martin, J.A., Curt
S.C., Mathews, T.J. (1997). Repor
Final Natality Statistics, 19
Monthly Vital Statistics Report. 45(1
(Suppl. 2). Hyattsville, Md.: Natio
Center for Health Statistics.

(IV.2) Ventura, S.J., Martin, J.A., Curt
S.C., Mathews, T.J. (1997). Repor
Final Natality Statistics, 19
Monthly Vital Statistics Report. 45(1
(Suppl. 2). Hyattsville, Md.: Natio
Center for Health Statistics.

(IV.3) Yudkowsky, B.K. (1996). *Analysis*
Medicaid Statistical File, FY1995.
Grove Village, Ill.: American Acade
of Pediatrics, Division of Health Pol
Research.

(IV.4) American Academy of Pediatrics. (1997). *Analysis of the March 1996 Demographic File.* Current Population Survey. Unpublished data.

(IV.5) American Academy of Pediatrics. (1997). *Analysis of the March 1996 Demographic File.* Current Population Survey. Unpublished data.

V. CITY DATA

(V.1) National Center for Health Statistics. (1997). *Detail Mortality and Natality Files, 1987-1995.* Unpublished Data.

(V.2) National Center for Health Statistics. (1997). *Detail Mortality and Natality Files, 1987-1995.* Unpublished Data.

(V.3) National Center for Health Statistics. (1997). *Detail Mortality and Natality Files, 1987-1995.* Unpublished Data.

(V.4) National Center for Health Statistics. (1997). *Detail Mortality and Natality Files, 1987-1995.* Unpublished Data.

(V.5) National Center for Health Statistics. (1997). *Detail Mortality and Natality Files, 1987-1995.* Unpublished Data.

VI. MCH TRENDS AND PROGRESS TOWARDS HEALTHY PEOPLE 2000

(VI.1) Office of the Assistant Secretary for Health. (1991). *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.* Public Health Service. Washington, D.C.: U.S. Government Printing Office.

CONTRIBUTORS

The Federal and non-government contributors to this publication include:

The National Center for Health Statistics, the U.S. Bureau of the Census, the Centers for Disease Control and Prevention, the U.S. Bureau of Labor Statistics, the U.S. Department of Education, the National Center on Child Abuse and Neglect, the University of Michigan Institute for Social Research, the Employee Benefit Research Institute, Abbott Laboratories, the Alan Guttmacher Institute, the American Academy of Pediatrics, and the National Conference of State Legislatures.

Under contract number 240-94-0047 with the Health Resources and Services Administration, the Public Health Foundation's Maternal and Child Health Information Resource Center produced this publication.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1997 418-662/60322

BEST COPY AVAILABLE

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Maternal and Child Health Bureau

DHHS Publication No. HRSA-M-DSLA-97-08 September 1997

HRSA

MCHB
Maternal and Child Health Bureau

BEST COPY AVAILABLE